
C New aged care model options

The Commission contracted Applied Aged Care Solutions Pty Ltd (AACS) to provide an independent report on a new aged care and assessment model. This appendix presents their report.

‘New Aged Care Model Options’

FOR THE PRODUCTIVITY COMMISSION

‘INQUIRY INTO CARING FOR OLDER AUSTRALIANS’

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January 2011



Glossary

AACS	Applied Aged Care Solutions
ACCNA-R	Australian Community Care Assessment revised
ACFI	Aged Care Funding Instrument
ADL	Activities of Daily Living
AH	Allied health
CACFI	Community ACFI
CACP	Community Aged Care Packages
Carer	Primary informal carer
CDC	Consumer directed care
CENA-R	Carer Eligibility Needs Assessment revised
Client	All persons broadly eligible for aged care programs (care recipients and carers)
Consumer	The general public, potential clients, others representing potential clients
CR	Care Recipient
CRCC	Commonwealth Respite & Carelink Centres
EACH	Extended Aged Care at Home packages
EACH-D	Extended Aged Care at Home for dementia packages
GP	General Practitioner
HACC	Home and Community Care
Hubs	Regionally based sites using nationally consistent assessment tools and processes but flexible to local and broader jurisdictional issues
IADL	Instrumental Activities of Daily Living
Lead Agency	The leading service provider where there is more than one service provider
MDS	Minimum Data Set
NRCP	National Respite for Carers Program
OH&S	Occupational Health and Safety
PC	Productivity Commission
QA	Quality Assurance
RCS	Resident Classification Scale
RTO	Registered Training Organisation
SP	Service Provider

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1: New Model Considerations

There are many shared principles stated in the various submissions to the Productivity Commission's Inquiry '*Caring for Older Australians*'. The purpose of this report is to describe an aged care system model that will accommodate many of the principles in a new way forward that places the client at the centre of the model and further improves the operation of the overall system that is designed to support older Australians. The suggested model reflects the principles in a practical and achievable way and is demonstrated and described in the suggested approaches for the provision of information, assessment, support and care for older Australians. The delivery of a new way forward will not only require a practical assessment and classification system but a re-configuring of the aged care programs moving from the current inflexible 'care package' approach where support service availability types and amounts are partitioned in a way that does not necessarily reflect the actual care need supports required for an individual. The new model reflects an approach where any required service (based on assessed care need) is available with the aged care classification the person achieves. The only restriction within the classification levels and special supplements (e.g. dementia low vs. high) is the amount of service (e.g. cost) that can be provided based on the individuals assessed care needs. This approach is more appropriate if we believe it is important to provide a fit between a person's care needs and supports the aged care program can provide. This new model will also provide for greater consumer choice with selection of the available service providers and level and type of assistance.

The new model also proposed a structuring of a central agency responsible for the overall aged care program management with the operational and service aspects performed by a network of regional hubs that could be managed at a jurisdictional level. This approach will provide for recognizable and accessible local hubs for consumers that will also serve to promote better co-operation between the various service system providers in the region and build capacity that will be responsive to local population needs and geographic and service system capacities.

The underlying principles in many of the submissions indicated that the purpose of the aged care system should be to assist the physical, emotional and social wellbeing of the person

and provide the opportunity for purposeful interaction with their community and family. This clearly identifies that the new aged care system should respect the client and their role in society allowing them a degree of control and self determination in terms of service types, amounts and providers that is not always apparent in the current approach.

The proposed model intends to incorporate the commonly shared principles and ideas enunciated in the submissions and place these ideas into a new structure of regionalized hubs using a defined process with standardised assessment and classification aspects that would underpin such a model.

1.1 PRINCIPLES

Assessment Model Principles

The proposed model is based on the most common principles described in the submissions to the Productivity Commission and discussed at AACs consultations. The model should allow for a nationally consistent process and assessment approach that provides for:

- Recognition of consumer rights, delivery of consumer choice and consumer control in their care support arrangements wherever possible and practical
- Consumer choice to be imbedded in the outcome of the assessment process that covers service types, service providers and care settings (as appropriate)
- Transparency of the assessment process, services available and outcomes expected for consumers and their families
- Information points that have detailed knowledge of eligibility requirements, the supports available and how to access them in a timely manner
- The provision of a central agency responsible for the overall aged care program management with the operational and service aspects performed by a network of regional hubs that could be managed at a jurisdictional level
- Consistency in the application of the information, assessment and classification approach that will produce equity of outcomes for consumers
- Seamless access to aged care services for consumers provides a clear, predictable pathway as their care needs change

- An approach that assesses for health promotion needs and the ability to improve independence, maintenance of independence and care needs that require ongoing support
- The recognition of the important role of the Carer and the need to support them in that role with a range of services not limited by the existing aged care program service types (awareness, access to supports, education and skill training, assessment in their own right)
- Access to a wide range of services (in and out of the community setting) from the central assessment agency hubs, covering the current HACC services and more to support consumer choice of setting of care e.g. palliative care, rehabilitation/restorative services, technological assistive devices
- Client referrals to be based on assessed needs and not restricted by what is available by any one service provider's offerings
- A fit with the promotion of wellbeing, healthy ageing, prevention programs and social inclusion activities
- A single aged care scheme that will streamline access to a wide range of aged care services e.g. from low level through to high care services
- Processes that interconnect the health and aged care systems in all jurisdictions in a nationally consistent way
- Electronic records that can reduce assessment burden for consumers and provide timely information for all service providers involved in the persons care. This will allow service responses to be better targeted and more responsive to the changing care needs of clients.
- An information platform that can bring together information from various systems and sources and builds a single client record (care recipient and carer) that is accessible to relevant service providers (as approved by the client and carer).
- A better fit with a market approach that provides incentives for providers to improve quality and innovation
- The identification of the unique issues of special needs groups with the maintenance of specific services designed to address these needs

1.2 BROAD REQUIREMENTS

This section will discuss the broad requirements needed to implement the principles described in Section 1.1. The new model would be ideally managed through the provision of a central agency responsible for the overall aged care program management with the operational and service aspects performed by a network of regional hubs that could be more directly supervised at a jurisdictional level. The broad requirements need to cover the new model aspects of:

- Information
- Assessment for identification of needs and classification
- Coordination and links to services

Consumer directed care will require access to information and other supports (coordination and independent advocacy by the regional assessment hub, case management at the service provision level) to assist the consumer to exercise their choice and control over service types, service providers and care settings. A clear and accurate information base should provide the basis for consumer decisions.

Studies have found strong evidence that service systems impact on the kind and amount of services received, producing inconsistency in the allocation of services based on resource availability rather than client characteristics (Howe, Doyle and Wells 2006¹). While the assessment used for classification and identification of needs should be undertaken independent of the Service Providers, consideration also needs to be given to the flow of the process and the system bottlenecks that may be produced as an unintended consequence. The evidence however also indicates that if the care needs assessment and classification outcome is determined in a setting independent of service provision, there are usually fewer regulations and requirements imposed on service providers by the body responsible for the funding of the services (e.g. government).

¹ Howe, A., Doyle, C., & Wells, Y. (2006) Targeting in community care: a review of recent literature and analysis of the Aged Care Assessment Program Minimum Data Set. Unpublished report to the Australian Department of Health and Ageing, Canberra.

An intake assessment is considered critical in allowing the client quick access to services and in directing the flow of the client through the system. Early access to services that promote independence will benefit the overall aged and health systems by encouraging use of services that can maintain or restore functional decline and this will in turn support people to live longer in the setting of their choice (Howe, Doyle and Wells 2006). It is therefore important that the assessment tool supports early identification of both current and emerging needs and easy access to services to support client independence.

A broad based intake assessment investigating current performance, impairments, dependency and support requirements should be conducted to properly inform on client needs. This intake assessment phase should not be influenced or affected by the local or available service resources as this will be considered at the referral stage of the assessment process. A broad client profile collected at the initial assessment stage will most likely identify a range of issues that can be then attended to in order of priority together with a plan to support the client to maintain their independence.

The intake assessment should:

- Be designed to fit with the assessment setting (online, phone and face to face)
- Be flexible and support best practices in assessment e.g. conversational approach
- Support an equitable process for clients by providing a consistent manner for identifying needs and determining supports and service selection
- Take a broad approach when looking at dependency, other care needs and unmet needs so as to be fully informed about the appropriate response for the client
- Support early identification of emerging care need issues
- Be fit to the purpose, providing an initial shorter assessment level (including self navigation, eligibility criteria), however with enough detail to support a classification approach and triggers to the next assessment level. The next assessment level should provide access to higher resource care packages that could be delivered in the community or residential settings
- Detail processes and tools to allow standardised input from external sources (e.g. health programs and specialist assessors), this will reduce assessment burden and assist communication between systems

- Be used by assessors trained in the methodology, use and assessment process supported by the specific tool. In the suggested new model the assessors are aged care comprehensive assessors and specialist assessors.
- Deliver reliable and useful data that can be shared as appropriate by agencies and service providers
- Provide governments with consistent information to manage and target resources in an equitable and sustainable manner at a regional and national level
- Produce a minimum data set for activity reporting and research purposes

A nationally consistent approach to intake assessment would be achieved by the assessment hubs which would be the entry or front end of the system, and would provide:

- Access and provision of consistent assessment at all regional locations across Australia via the regionally based assessment hubs
- The network of regionally based integrated assessment hubs would play an essential role in coordinating client assessment information and supporting service providers in the regional network
- Client classification details and advise on any co-payment requirements
- Support for consumer directed care by including the consumer in the planning aspects including client goal setting, priorities and desired client outcomes as an indicator of service 'pack' effectiveness
- An independent review of services and the service outcomes with services based in the regional network
- An independent advocacy service for consumers receiving services from providers based in the regional networks

1.3 CLASSIFICATION CONSIDERATIONS

What are the features of a classification model for an aged care program providing services across community and residential settings? The determination of the features will inform on the final selection of the criteria, assessment questionnaire content and statistical model that is required to determine the classifications. The model and associated instruments will need to be flexible enough to include the required options.

Eligibility needs to be determined to ensure that objective criteria are developed for the 'bottom end' of the classification model. For example:

- Eligibility for care programs may be limited to people with reaching a specific level of care need in one area or across many care domain areas. This is effectively the approach used in Australia via the Aged Care Assessment Team (ACAT) system. An ACAT determines a person as being 'eligible' for specific types of care based on the person's level of care need. If determined as eligible by the ACAT for higher level community care the person is then also assigned the type and level (effectively funding) of assistance required (e.g. EACH package). In this case the ACAT effectively determines the payment allocation 'group' that the client is eligible for based on the ACATs assessment of care needs. If however the ACAT recommends that the client is eligible for residential care, the persons funding allocation is not determined by the ACAT but by the ACFI assessment conducted by the residential facility. In this case the ACFI assessment provides for a number of funding levels based on the average cost of services for a person in a particular care need group
- Eligibility may be limited to people meeting a set criteria such as chronological age
- Eligibility may be limited to a set number of people that can be funded out of a pre-set budget amount. For example domestic assistance may be provided for a fixed number of people in a geographical area for a set period of time. After this time period other people who have applied can then receive the service

2: Report Background

2.1 METHODOLOGY

The methodology section will describe the outcomes of the background review for this project. It will describe:

- Project scope
- International and Australian perspectives on aged care programs including feedback from consultations with some of the submission authors

2.2 PROJECT SCOPE

The scope of this paper covers the design an assessment model at the front end of the aged care system. The assessment model will determine the relative resource allocation for aged care services that could be provided in residential and community care settings. Ideally the assessment will be a single instrument that would include a set of core items (e.g. a Minimum Data Set) to be applied across all settings, perhaps with data sub-sets collected for particular settings. The MDS would be completed using various suitable assessment tool/s. The assessment tools need to have met a set of standards that provide evidence that the tool has been validated for use with the target audience by the anticipated users. The assessment tools should be validated in a broadly based trial with the target audience and actual users.

Setting

The model will cover current community and residential aged care programs and services that are funded or part funded by the Commonwealth Government:

- Home and Community Care [HACC]
- Community therapy and support services (Day Therapy Centres and the Assistance with Care and Housing for the Aged Program)

- Respite services: National Respite for Carers Program – grant based for carers [NRCP] and residential respite arrangements – for the client (high and low care)
- Community Aged Care Packages (CACPs)
- Extended Aged Care at Home Dementia Packages (EACH-D)
- Extended Aged Care at Home Packages (EACH)
- Residential Aged Care – low and high care

Participants

The model will describe the roles and activities of:

- The gateways for intake and assessment using regional hubs that interact with the client and local service providers
- Persons eligible for aged care programs
- Carers for persons eligible for these care programs
- Service Providers of aged care services
- Other Health Systems and Agencies that interface with the system e.g. health system, specialist assessment agencies

2.3 AGED CARE PERSPECTIVES

2.3.1 Introduction

The characteristics of international and Australian approaches used in lower level community care, higher level community care, residential care and respite care for recipients of services and their caregivers, will be briefly described in relationship to eligibility, assessment and classification approaches (refer to Table 2.1).

In particular, Table 2.1 describes:

- Aged care service models and principles, and scope of services offered
- Eligibility criteria

- Assessment features - who completes the assessment, type of assessment domains, strengths and weaknesses
- Classification features – how it is determined and used

The countries in Table 2.1 are grouped as follows:

- Austria and Germany
- Sweden, Denmark and the Netherlands
- UK and New Zealand
- USA
- Japan
- Australia

Table 2.2 then describes the Australian Community Care Programs (HACC and community care packages) in terms of:

- Purpose
- Eligibility
- Assessment
- MDS
- Services provided
- Differences between the programs
- Program Issues
- Other programs offered at these levels

This is followed by a general discussion of the findings.

2.3.2 Overview of findings

Table 2.1: Aged Care Perspectives

Countries	Broad model features	Eligibility	Assessment	Classification	Australia in comparison
Germany Austria	<p>Focus on permanent care. Consumer choice of setting. Offer cash or services or institutional care. Offer limited respite and economic (pension) assistance. Focus on Disability and Functional needs.</p>	<p>Access to community and residential services determined by single assessment.</p>	<p>Medical and Health Professional team. Face to face assessment. Functional focus, not comprehensive. Independent of Service Providers. Not standardised. No case management.</p>	<p>Three levels based on hours of care or frequency of assistance.</p>	<p>Covers more than permanent care (transitional care, prevention treatments, early intervention, low intensity, coordinated low care, coordinated high care).</p> <p>Eligibility is assessed separately for community and residential level care.</p> <p>Community Care:</p> <ul style="list-style-type: none"> HACC eligibility for low intensity services NRCP for carer support DVA for veteran affairs programs ACAT for DTC, respite, transitional care, community care packages (coordinated low and high care) <p>Residential Care:</p> <ul style="list-style-type: none"> ACAT determine eligibility for low/high care general levels only Residential care has a separate assessment (ACFI) for the funding ACFI completed by the residential provider Separate assessment services for different community services (HACC, NRCP, VHC, DTC/respite/Community care packages/transitional care).

Countries	Broad model features	Eligibility	Assessment	Classification	Australia in comparison
Denmark Netherlands Sweden	<p>Housing and welfare approach. Offer specially built neighbourhoods, sheltered housing, home modifications.</p> <p>Decentralised, non-medical, de institutionalisation. Consumer choice. Institutional care is being phased out in Denmark. In Sweden the community is the provider of services.</p> <p>Offer cash or services. Offer economic, respite, and personal support.</p>	Access to community and residential services determined by single assessment.	<p>Multi disciplinary team. Regional assessment organisations. Face to face assessment. Comprehensive assessment. Independent of Service Providers.</p> <p>Not standardised, not structured.</p> <p>Case management for service targeting, coordination and enhanced outcomes.</p>	<p>No classifications in Denmark and Sweden. Assessment team and consumer determine services and setting. Case manager discretion in amounts of services provided.</p> <p>Netherlands base levels on hours of care.</p> <p>Denmark and Sweden offer cash to select own Service Provider, the consumer creates the relationship with the Service Provider</p>	<ul style="list-style-type: none"> Multiple respite programs e.g. NRCP, HACC <p>Not as developed regarding housing options.</p> <p>Not fully decentralised.</p> <p>No de institutionalisation principle, however supporting home and community services option.</p> <p>Carer Payment and Carer Allowance.</p> <p>Carer Support services through NRCP programs.</p>
USA	<p>Welfare based, weighted to institutional care (highest funding).</p> <p>Funded primarily by federal subsidies (Medicare and Medicaid) and out of pocket costs. There is a low amount of private insurance.</p> <p>This is a managed care model with limited home care coverage.</p> <p>There has been an improving recognition of caregiver needs in the US seen through growing caregiver legislation at federal and state levels.</p> <p>The US Federal Government provided assistance to family caregivers, through the Older Americans Act's National Family Caregiver Support Program (NFCSP) in 2000, the Family and Medical</p>	Access to community and residential services determined by multiple assessments.	<p>RAI for LTC (Nursing Homes) produces a MDS. Multi disciplinary.</p> <p>Not independent.</p> <p>Face to face assessment. Trained assessors (manuals, training etc). Assessment produces Care Plans and Resource Allocation (the seven case mix levels).</p>	<p>Computer produced algorithm levels.</p> <p>USA nursing homes have 7 case mix levels:</p> <ul style="list-style-type: none"> Rehabilitation Medical Special Care Complex Cognition Behaviour Physical Functioning 	<p>ACFI assessment produces the classification funding levels for low or high care in residential care, based on the level of need in three case types (ADL, Dementia & Behaviour, Complex Health Care).</p> <p>ACFI does not produce a comprehensive Care Plan.</p> <p>Recent Australian reports have focused attention squarely on the reform needed in the community care sector, to prepare for the future. The 2009 Commonwealth of Australia's House of Representatives report 'Who Cares..?' into better support for carers operates within several policy contexts.</p> <p>The International and Australian policy directions highlight the need</p>

Countries	Broad model features	Eligibility	Assessment	Classification	Australia in comparison
	<p>Leave Act (FMLA) of 1993, and through Medicaid Home and Community-Based Services (HCBS) waiver programs that include respite care for family caregivers. Between 2004 and 2006 the three most common strategies were:</p> <ul style="list-style-type: none"> ■ Caregiver tax incentives ■ Family and medical leave policies ■ Respite care provisions 				for a nationally consistent assessment approach across multiple carer programs (to assist carer access and reduce carer burden) that assesses a broad range of carer and care recipient needs to fully support carers in their care giving role. A nationally consistent and comprehensive data approach can help to equitably identify carer needs, assist efficient use of resources and provide program planning data.
USA: Wisconsin model	<p>Integrated program of health and long term care designed to improve access and quality while achieving cost savings.</p> <p>The intervention is service coordination for consumers, includes service contracts with providers. Aim is to reduce entry to hospitals and Nursing Homes. Includes preventative care. Flexibility to suit consumer choice, combines managed care in a risk based environment.</p> <ul style="list-style-type: none"> ■ Control health costs ■ Comprehensive range of services in the community ■ Coordinated care across systems ■ Improve health outcomes ■ Increase participant decision making ■ Increase quality (consumer defined measures of quality) 	<p>They have targeted client types who are eligible for Medicaid and meet nursing home level of care.</p> <p>Voluntary participation.</p> <p>Access to community services determined by single assessment.</p>	<p>Includes Goal setting to understand the client's needs.</p> <p>Needs assessment based on RAI.</p> <p>Interdisciplinary team model. Independent of service provider.</p> <p>Community based organisations sub contract with hospitals, clinics, HMO and other providers of acute and LTC services</p>	<p>They combine funding from Medicaid and Medicare into one program. Avoids fragmentation and duplication of services. The package is individualised.</p>	<p>Community care packages offer residential level care in a community setting with case management (service coordination). Community care packages Not as flexible.</p> <p>Assessment by ACAT to determine eligibility. Another assessment by service coordination service (separate to ACAT).</p> <p>Limited number of packages, provision of residential places and community care packages based on regional demographics.</p>
Japan	<p>Long term care insurance. Positive ageing philosophy</p>	Access to community and	Nationally standardised comprehensive	Computer algorithm results in a case mix model	HACC and VHC assessors are not independent of community care

Countries	Broad model features	Eligibility	Assessment	Classification	Australia in comparison
	including preventative services.	residential services determined by single assessment.	assessment. Qualified assessors (standard training and examination). Not required to be independent of providers. Comprehensive assessment, modified RAI. Domains of ADL, IADL, rehabilitation, Behaviour, Medical Treatment.	of: <ul style="list-style-type: none"> ADL difficulties Moderate handicap Heavy Care Heavy care with special needs Bedridden/dementia Only one level (ADL) limited to community setting e.g. no choice in setting provided.	<p>providers; they also provide information to consumers.</p> <p>NRCP assessors are independent of providers; they also provide information to consumers.</p> <p>ACAT are independent of aged care providers; they also provide information to consumers.</p> <p>ACFI assessors are not independent of residential care providers.</p>
UK/New Zealand	<p>Decentralised- in the UK they have regional primary care trusts; in New Zealand they have District Health Boards.</p> <p>Consumer choice. Moving away from favouring institutional care. Person centred. Evidence based guidelines.</p> <p>The New Zealand government has a <i>Carers' Strategy and Five-year Action Plan</i>. This was published on 28 April 2008.</p> <p>The UK legislation and policies concerning carers is quite developed. Carers (Recognition and Services) Act 1995 - the carer's right to an assessment of his/her own needs.</p> <p>This was extended under Standard 6 of the National Service Framework (NSF) to an assessment of their caring, physical and mental health needs, with a written care plan which includes carer input.</p> <p>Carers (Equal Opportunities) Act</p>	Access to community and residential services determined by single assessment. Needs assessment and income tested.	<p>Comprehensive assessment by quality assessors.</p> <p>Case management.</p> <p>Nationally accredited toolboxes, with a national MDS.</p> <p>Provide information on services.</p> <p>Access to medical advice.</p> <p>Admission to acute.</p> <p>Provide reviews.</p> <p>Include consumers in decision making.</p>	<p>Have classifications, but not algorithm based, assessor determines levels.</p> <p>Local authority/regional budgets, not individual funding.</p> <p>Budgets are controlled by the regions, while this allows for individualised approaches it is potentially open to inequity due to a lack of systematic approaches.</p>	<p>Shared principles</p> <ul style="list-style-type: none"> Consumer choice Person centred Offering more community care <p>Aged care is separate to the health system.</p> <p>There are separate assessment pathways for community and residential care. ACAT can provide a level of integration.</p> <p>Funding for HACC services is provided through funding agreements between State/Territory governments and Service providers for care services to a cohort of eligible recipients</p> <p>Funding at residential care level (community care packages or care in residential setting) is calculated for individuals at fixed levels, and given to service/facility providers who then provide care services to a cohort of eligible recipients.</p>

Countries	Broad model features	Eligibility	Assessment	Classification	Australia in comparison
	<p>2004 focuses on carers' health, employment and life-long learning issues. The Bill placed responsibility on local authority social services departments in informing carers of their rights and to promote carer health and welfare</p> <p>In June 2008 the British National Government launched the policy document "Carers at the heart of 21st Century families and communities".</p>				<p>Australian government report on carers 'Who Cares...?' (2009)</p> <p>Report on the inquiry into better support for carers had similar outcomes as the UK reports. They recommended identifying all carers, providing them with their own comprehensive assessment, in a nationally consistent approach with a national data collection, and across government departments – disability, mental health, aged care.</p>

Table 2.2: Community Care Program Comparisons

Program	Home and Community Care	Community Aged Care Packages	Extended Aged Care at Home packages	EACH - Dementia
Acronym	HACC	CACPs	EACH	EACH-D
Purpose	A program of basic maintenance and support services for frail older people and the carers of these people to prevent premature admission to residential care and that promote independence at home and in the community.	Alternative community setting for persons who meet eligibility for residential low care. Individually planned, coordinated and managed packages of community aged care services targeted to those with complex care needs. Recipients would otherwise be eligible for at least low level residential care.	Alternative community setting for older persons [younger people with disabilities are generally not considered for EACH Packages] who meet eligibility for high level residential care but who have expressed a preference to live at home. Individually planned, coordinated and managed packages of community aged care services to provide for complex care needs of older people. Designed to 'complement' CACPs	Alternative community setting for persons who meet eligibility for high level residential care and have behaviours of concern associated with dementia. To provide a coordinated and managed care package to people with dementia who have behaviours of concern. These behaviours have a significant impact on their QOL. Without EACH-D client would be at risk of admission to a dementia specific high care aged care facility. ACAT approval for high level aged care and suitable to remain in community
Eligibility Criteria	Elderly Disability HACC Service provider can determine eligibility ACAT can recommend HACC services and refer client back to service provider	ACAT approval for low level aged care and suitable to remain in community	ACAT approval for high level aged care and suitable to remain in community	
Assessment	Individual Service Provider Assessments A National assessment instrument ACCNA-R/CENA-R) has been developed.	Service Provider assessment which is not standardised, some items reported in ACCMIS* database and possibly SPARC (Aged Care payment system) database.		
MDS	HACC MDS Various State MDS: SCoTT; INI; ONI	ACCR MDS. Aged Care Client Record (ACCR) completed by ACAT, there is a smaller subset of data recorded in the minimum data set (Parts 1-4 and 6-7). ACCMIS		
Services provided	<ul style="list-style-type: none"> Domestic assistance Social Support Nursing Care Allied Health Care Personal Care Centre based respite care Food services 	<p>Similar to HACC but no Nursing Care or Allied Health also has on call access.</p> <p>Principally designed to meet client's daily needs including personal assistance which may include: bathing, showering, personal hygiene, toileting,</p>	<p>Similar to CACP but generally includes qualified nursing in the design and ongoing management of the package and allied health services.</p>	<p>Same as EACH package with additional emphasis on dementia specific services assessment and care plan development and monitoring, and direct care workers skilled in knowledge of dementia and appropriate behavioural support interventions and programs.</p>

Program	Home and Community Care	Community Aged Care Packages	Extended Aged Care at Home packages	EACH - Dementia
	<ul style="list-style-type: none"> • Respite • Assessment • Case management • Home maintenance • Counselling/ support, information, advocacy • Aids & Equipment • Transport for shopping, appointments and activities 	<p>dressing or undressing, mobility, transfer, preparation and eating meals, sensory communication, or fitting sensory communication aids, laundry, home help, gardening and short term illness. Also may include, control and administration of meds, rehab support, admin of treatment such as eye drops, back rubs, dressings, urine tests, emotional support and direct supervision, assistance with special diet, responsible agency/person on call for emergency assistance, transport to shop or go to doctor, social activities, temporary in home respite, support services to maintain personal affairs and to protect the person's interests.</p>	<p>General Services</p> <ul style="list-style-type: none"> • Administration • Care Planning management <p>Clinical Services (registered nurse provided or supervised directly/indirectly)</p> <ul style="list-style-type: none"> • Clinical Care (e.g. pain, complex health care) • Access to Health services <p>Care Services (excludes service if the care recipient & carer choose and/or is able to provide these for self)</p> <ul style="list-style-type: none"> • ADLs • Nutrition, hydration and meal preparation • Skin integrity management • Continence management • Supports for cognitive impairment • Mobility and dexterity • Leisure and activities • Emotional support • Therapy services • On call access • Home safety • Home maintenance • Minor Home modification • Oxygen and enteral feeding supplements 	
How does this program differ from others?	Nursing is provided in HACC but not in CACPs	It includes a case management component. A requirement for coordination of services without which the client would be at risk of admission to an aged care facility.	<p>EACH is distinguishable from CACPs in terms of complexity and intensity of service needs. Where possible ACATs should work with EACH providers to help develop a care plan in line with the client's assessed needs. Ongoing assessments by the EACH provider (at least 6 monthly) to identify changes in both their care needs and in the role of their carers so that the package can best respond to those needs.</p>	<p>Three characteristics distinguish these packages from EACH. 1. Highly skilled, dementia specific case management. 2. Flexible, innovative delivery & mix of services. 3. Linkage to specialist services and supports. Where possible ACATs should work with EACH providers to help develop a care plan in line with the client's assessed needs. Ongoing assessments by the EACH provider (at least 6 monthly) to identify changes in both their care needs and in the role of</p>

Program	Home and Community Care	Community Aged Care Packages	Extended Aged Care at Home packages	EACH - Dementia
Program Issues	<p>Except in special programs such as COPs in Victoria, case management is not seen as being part of the program. Sometimes, clients move to CACPs, even though their level of care does not warrant it, purely for case management/ coordination purposes.</p> <p>A small number of clients are receiving a disproportionate amount of the HACC budget. Allen report (2006) estimated that 33% of the HACC budget is spent on 3% of HACC clients. These HACC clients have similar characteristics to CACP clients. The DoHA submission(2010) also stated that:</p> <ul style="list-style-type: none"> 2.1% of all HACC users aged 65 or older were funded above CACP 75% funded below CACP <p>There are differences between programs, for example different amounts of respite are available from different programs- NRCP, DVA, HACC. There are differences within programs across jurisdictions e.g. different levels/types of services for clients with similar characteristics.</p>	<p>Does not include provision for nursing. Sometimes people go onto a CACP from HACC even though their care does not warrant it, purely for case management/coordination purposes. Significant numbers of CACPs clients use HACC services also, particularly nursing services. Full cost recovery if CACPs purchases services from HACC.</p> <p>The Package Provider makes the final decision to accept an approved person as a client.</p> <p>There are differences within programs across jurisdictions e.g. different levels/types of services for clients with similar characteristics.</p>	<p>Only really effective with full time live in carer. Difficulties with appropriate short term residential care - respite, access to services such as day centres difficult. Difficult to maintain level of services in rural areas. Difficult to get service providers to take on extra burden of home visits etc e.g. GPs. Lack of geriatricians and mental health providers in many areas. Funding gaps when a person goes off another package and onto EACH, due to the assessment phase etc, the funding needs to continue, particularly for example going to EACH from CACPs. Additional funding required for those without a full time live in carer. Equipment funding inadequate at beginning, palliative care inadequately funded at end of life. Difficulties in funding the necessary time to assess and put appropriate services in place. Full cost recovery if EACH purchases services from HACC.</p> <p>As for CACPs, the Package Provider makes the final decision to accept an approved person as a client.</p> <p>There are differences within programs across jurisdictions e.g. different levels/types of services for clients with similar characteristics.</p>	<p>their carers so that the package can best respond to those needs.</p> <p>Same as EACH, but more difficulties with specialised practitioners in some areas.</p> <p>As for CACPs and EACH, the Package Provider makes the final decision to accept an approved person as a client.</p>
Other programs that provide for similar level of care.	<p>DVA services, NRCP programs and DTC are accessed via other pathways.</p> <p>DVA home care provide low level services to veterans including gardening, house maintenance, domestic assistance, personal care</p>	<p>All these programs are accessed via the ACAT pathway.</p> <p>Residential Low Care</p> <p>Transition care: Aged care client in community enters</p>	<p>All these programs are accessed via the ACAT pathway.</p> <p>Residential High Care</p> <p>Transition care</p>	

Program	Home and Community Care	Community Aged Care Packages	Extended Aged Care at Home packages	EACH - Dementia
	<p>and respite.</p> <p>DVA community nursing provides nursing services to veterans.</p> <p>Day Therapy Centres are Commonwealth funded and provide therapy services to aged care clients.</p> <p>NRCP provides carer support and respite</p>	<p>acute health hospital.</p> <p>Aged care client due for discharge from hospital.</p> <p>Assessed by ACAT as meeting residential care eligibility.</p> <p>Suitable for transitional care package to provide extra services in the short term to avoid entering residential care full time.</p>		

2.3.3 Discussion

Ageing in place

There has been an increasing desire in Australia from older people and in general from the wider community for older people to remain living in a supported manner in their own home or other private accommodation settings for as long as it is feasible, affordable and safe. This is demonstrated by the demand on the Commonwealth and State funded HACC Program services and the steadily increasing allocations of Commonwealth funded community aged care places (residential 'equivalent' care packages provided in community settings). People now live in the community with higher care need levels than was previously the case 20 years ago in part because of the availability of these in-home support services previously confined to residential care environments.

Where living in a person's own home is no longer possible, the emerging practice in Australia and internationally is for the congregate or residential environment to be capable of providing an ageing in place support model. In this approach the person can stay in a familiar place, build social connections with other residents and staff while having their changing care needs met by the care model, without needing another move to, for example, a higher care facility. This approach effectively separates the accommodation and hotel aspects of support from the care provision aspects which are then tailored to individual need. This approach reflects the international trends in the development of flexible care residential environments and supports the practice of ageing in place. Australia however presently maintains for the most part a two tier approach of predominantly lower care and higher care residential environments although the balance of this mix is changing as Commonwealth funded residential care becomes more focused on people with higher levels of care need requirements. In terms of international approaches where even people with high care needs are supported in community care type settings, Scandinavia appears to be the most advanced in offering a broad range of accommodation choices with the use of innovative community housing models that can offer an alternative to institutional high care.

Consumer decision making

Consumer choice and participation in decision making can be seen in many of the international models. Scandinavian countries have a strong principle of including the consumer in the decision making process and the lack of defined classification rules allows them to be flexible in responding to the client's needs. However this approach can potentially be open to inequitable outcomes due to assessor bias. In Japan they have official pathways (e.g. local boards) to ensure the consumer has a

voice in the decision making to ensure they will receive a fair hearing and say in the outcomes of the assessment.

Eligibility, Information & Assessment

The majority of international models have a single system with an independent approach to information, eligibility and assessment for care and this may reduce the difficulty for clients navigating the system. The Australian model in comparison is sometimes referred to as confusing, complex, lacks a continuum of care/ seamless experience and appearance due to the multiple number of entry points, differing levels of information provided and the multiple assessments required.

The Australian community care model relies on:

- (i) ACATs to provide an independent consistent assessment approach for access to the higher level care spectrum as well as information about the aged care system. It has a gatekeeper role in determining eligibility for residential and some 'residential equivalent' community programs (community care packages) and Commonwealth funded community programs (e.g. DTC, respite, transitional care). However not all aged care clients will access services via an ACAT recommendation or referral. The actual assessments and information provided may vary between ACATs and between jurisdictions.
- (ii) Community Care Service Providers determine access to the base level of community care services (for HACC, VHC) for clients not required to have an ACAT assessment. Clients will often rely on the Community Care Service Provider to provide information about the system. In some cases Service Provider information may be limited to services they provide and not the broader aged care system options available to the client.
- (iii) There are other services and organisations that can provide information about the aged care system. Some are Commonwealth funded agencies such as the national network of Commonwealth Respite and Carelink Centres, State government agencies , local governments, general health care providers (GPs, acute hospitals, community health centres etc) and aged care service providers. The service may be provided by telephone, face to face, or online. The consumer needs to be well informed about the options, then able to collate the information and work their best options in the current circumstances.

- (iv) The National Respite for Carers Program (NRCP) carer support program also provides access for carers to various support programs (e.g. respite, support groups etc.) through the Commonwealth Respite and Carelink Centres.

The Australian aged care client moves between the different services and programs as their need change. Some may receive some integration assistance in the form of case management if they have a community care package. If having multiple care needs they will often be assessed by the range of service providers who service each need area unless the Service Provider is large with a full range of programs available. The consumer will often rely on these Service Providers for information unless they can navigate through the maze of possible sources of information and services. While this system has been largely effective in assisting older Australians it could be more co-ordinated. This would better assist the consumer to be properly and fully informed about their aged care options promoting their ability to make informed decisions as their needs change.

What services are important in a community aged care program delivery?

Currently there are different entry points for different service types. For example the assessment and eligibility to HACC community services is separate to assessment and service to the higher level care packages (e.g. CACP, EACH, EACH-D) provided in the community. This results in a multitude of assessments from different services that clients undergo as their needs become more dependent and complex. To incorporate integrated assessments services and access to services in the client's setting of choice, the community aged care program client needs access to a wide range of services. The literature and the feedback from consultations would suggest that the most important elements of any home based support is that it provides services along a continuum of care, and would include HACC type services and those services that are currently found in the CACPs and EACH/D packages. Table 2.3 presents a list of services described by the World Health Organisation (WHO) organisation that should be available in a mature aged care system.

Table 2.3: Elements of Quality Long Term Care

Service Type
Preparation and mobilisation of society and the community for caring roles
Development of voluntary work and provision of volunteer opportunities to clients
Health promotion, health protection, disease prevention, postponement of disability e.g. wellness approach, independence approach

Provision of information to consumers, family, and general public
Assessment, monitoring, and reassessment
Coordination services to assist clients navigate through the system
Community-based restorative and rehabilitation services
Referral and linkage to community resources
Facilitation of self-care, self-help, mutual aid, and advocacy
Opportunities for productive activities, recreation, physical activities
Facilitation of social interaction and development of informal networks
Physical adaptation and maintenance of the home
Health care, including medical, medication, nursing care
Personal care, e.g. grooming, bathing, meals
Household assistance, e.g. cleaning, laundry, shopping, nutrition
Provision of supplies (basic and specialised), assistive devices and equipment (e.g. hearing aids, walking frames), and drugs
Alternative therapies and traditional healing
Specialised support (e.g. for incontinence, dementia and other mental problems, substance abuse)
Respite care (at home or in a group setting)
Palliative care provided at home or in residential setting e.g. management of pain and other symptoms
Counselling and emotional support
Education and training for clients and informal/formal caregivers
Support for caregivers before, during, and after periods of care-giving

Classification for Care Needs, Program Allocation and Funding

Most countries base the classification on the basic functional needs of clients (IADLs - independent living skills and ADLs - personal care and mobility needs) often incorporating psychosocial needs (emotional, cognitive, behavioural).

There is various classification approaches reported in the international literature. Countries with non independent assessors (USA and Japan) demonstrated an objective or computer based algorithm approach to funding classification as this was believed to reduce assessor bias. Countries with independent assessors varied their classification approaches:

- Some (UK, NZ) described set levels but allowed assessors to determine which level the client fitted into
- Others (Germany and Austria) provided objective algorithms (e.g. number of ADLs, frequency of assistance) to determine the level of care need and program eligibility

- While the Scandinavian countries of Sweden and Denmark do not appear to have any formal classification levels based on assessment tools or questionnaires

There are several elements that need to be considered in determining the purpose of the classification approach. For example:

- An objective classification based on a standardised assessment tool will provide a more consistent approach to client resource allocation by directing similar funding to similar types of clients. The classification determines the funding and the assessment the types of services relevant to meet the client's needs
- While the classification and funding may be similar for some clients the assessor and the client must be given flexibility in the final determination of service types and amounts (within the allocated budget) to allow for flexibility to meet individual situations
- An algorithm based classification system will determine the minimum data required to determine classification for funding
- The purpose of the assessment determines the scope and depth of the domains covered in the assessment. For example if the assessment purpose includes detailed care planning then more depth of information is required than for classification purposes. The classification for funding and program eligibility should form a natural outcome of the assessment tools
- Any classification model used in the Australian context needs to be derived as an outcome of the assessment toolkit used to assess the care need requirements of clients

Inclusion of carers

Inclusion of the carer's needs to provide for a holistic assessment is also gaining international recognition. The International and Australian policy directions highlight the need for a nationally consistent assessment approach across multiple carer programs (to assist carer access and reduce carer burden), assessing a broad range of carer and care recipient needs to fully support carers in their care giving role. A nationally consistent and comprehensive approach to carer assessment can identify carer needs, assist efficient use of resources when couples are being supported by multiple programs and provide program planning data.

Australian policy and reform documents have a number of recommendations for future changes or reforms which could impact on carer assessment in the future. They make recommendations for the consolidation and integration of existing programs, for example across disability, mental health and aged care.

Common Assessment

The international literature reports that most countries have a single assessment approach that links home based care, community care and residential sector into a consolidated funding model. A common assessment approach for all clients (care recipients and carers) should be adopted for several reasons including:

- The need to clarify and then streamline eligibility for ease of access to required services
- The need to target information only as required i.e. simple (or quicker) assessment for low levels of support at home, through to more rigorous assessment to determine eligibility for higher levels of community and residential care
- The use of a common language for defining need to allow all stakeholders to understand the outcomes of the assessment process
- The need to reduce the requirement for people to undergo multiple assessment in order to access services
- To enhance the flow of health information and communications among patients and health professionals throughout the country
- To link assessment criteria to classification models
- To measure and improve health and performance outcomes
- To use the data collection and reporting from systems to help inform funding allocation, track progress, assist in determining the relationship between care needs and the cost of services in community care and assistance with policy formation
- To enhance decision-making, drive improvements in clinical practice, guide how resources are marshalled and deployed and provide the basis for feedback loops to promote improvement in access to, and quality and efficiency of care

Exploring New Funding Models in the Australian Community Care

Packaged care can be described as the provision of community care services to those individuals with 'intense and/or complex care needs'. To be eligible for a care package, clients must be assessed and then approved by an Aged Care Assessment Team (ACAT). The care package, in effect, is to some extent a residential care funding 'related adjusted subsidy' without the accommodation and hotel services components. It is paid directly to the service provider to support an eligible client living in the community who can use all the package funding or a proportion of the funding on an individual client. Recipients of care packages would otherwise be eligible for at least low level residential care accommodation and a subsidy based on their ACFI level. Currently, the formalised care packages available are CACPs (Community Aged Care Packages), EACH (Extended Aged Care at

Home) and EACH-D (Extended Aged Care at Home - Dementia) as well as other 'top-up' care packages using HACC funding namely Linkages (Victoria) and the High Needs Pool (NSW). The higher level care packages are supplemented by HACC services such as nursing support. Packages of care comprise a range of different services and providers.

CACPs and EACH packages which were legislated in the Aged Care Act 1997 are based on the provision of fixed levels of subsidy to local service providers who then provide care services to a cohort of eligible recipients. The agencies at a local level decide upon their client mix with regard to the resources they have available. In some cases the local agencies provide the services directly to clients, in others they subcontract services to meet needs of clients and fill gaps in their own service provision offering. The quality assurance approach for the EACH program indicates that providers are to demonstrate continuous quality improvement and staff are to have appropriate training, knowledge, and skills. There are legal standards of care for EACH Packages and providers can have sanctions placed upon them and suspension of allocated funds if they are found to be not met. However the audit process is not as comprehensive as is the case with Commonwealth funded residential care program. Residential care is audited through accreditation standards and facility visits and funding reviews.

The services provided in the Australian packages generally provide more services for clients with increasing and more complex care needs but there are some inconsistencies in service type availability (refer to Table 2.2). This has led to CACP packages being topped up with HACC services but at full cost recovery and higher costs for the user (i.e. because the service is not subsidised by the multiple funders at the HACC level). Many clients are therefore unwilling to leave the HACC level services because they may incur a higher level of user payments with CACP provided services. This is demonstrated in nursing services which are covered at the HACC level but not in the next most complex service level (CACPs Package). Also the availability of packages at the local level impacts on which package type is allocated. For example a client may be eligible for an EACH-D package but only an EACH package is available in some geographical areas. In these cases the person will be allocated what is most suitable and available at the time and this can result in a wide variation in the content and amount of services offered in packages. The variations in services provided within and between packages are in part reported as an outcome of the funding constraints (this is discussed further in the next section).

The Aged Care Assessment Teams (ACATs) provide a single entry point for access to aged care residential and higher level community care programs. The assessment undertaken by the ACATs for eligibility to these programs is not based on a nationally consistent assessment tool kit and algorithm to guide the assessor's judgement (the MDS is standard). It is determined by the assessor's interpretation of their assessment outcomes including the minimum data set items and the ACAT guidelines. While a detailed knowledge of the package eligibility is a strong part of the skill set of ACAT assessors, there is a high likelihood of inconsistency regarding the determination of eligible and ineligible persons because of the level of interpretation that is necessary. In most cases where there may be some doubt it is probable that the ACAT assessors would choose to err on the side of recommending approval for a package and low level residential care. This would lead to high level of sensitivity (almost all people that were truly eligible would be recommended for a package) but a low level of specificity (a number of people not immediately appropriate for the package would also be recommended) as the temptation is to over select people for a package. The eligibility for a package could be made more objective and consistent if a particular score or pattern of rated outcomes was required.

The Australian Government in its document 'A New Strategy for Community Care – The Way Forward' proposes a tiered model of community care that will allow clients needs to be met in a more integrated fashion that recognises the continuity of care philosophy. Action 1 in the document (DoHA, March 2003, page 26) seeks to achieve greater alignment of CACPs and EACH packages with other services in the Packaged Care tier and HACC programs. This direction is supported by the evidence from recent package program reviews (e.g. "Understanding Formal and Informal Packaged Care for Older Australians", The Allen Consulting Group, 2006) that indicate that there is a continuum of hours used by HACC clients, a significant overlap between the characteristics of CACPs and EACH clients and a large variation in support hours within the package programs.

The Allen Report suggested a level of 4.5 hours a week of HACC services to be a benchmark where people may be eligible for packaged care services. Using this, in 2004-05, 3% of HACC clients who may have been eligible for packaged services used 33% of HACC funds. The Allen group also found that there are similar numbers of clients on CACPs (30,000) and high end HACC users (25,000). The AIHW has done linkage work across the CACP and HACC programs. Significant numbers of clients simultaneously use both service types. The service boundaries are often blurred and HACC services may be used to plug service gaps in CACPs packages. This particularly relates to nursing services. As indicated earlier there are the additional issues related to HACC services being cheaper for clients

and covering nursing services whereas CACPs are more costly for clients with nursing care needs as nursing services are not included in the CACPs package. Additionally, in regional and remote areas, HACC services supplement CACPs and EACH programs where there is insufficient staff to cover the support needs of the package services. Even in larger cities, workforce issues play a part in the utilization of packages. The work of Allen consulting on standardized care hours per week used by client's shows that there are many clients on EACH packages who are getting less service hours than they would on a CACPs package although the cost of these services may vary. It is also apparent that there is 'cherry picking' in the current package system where some organisations select only those clients needing low levels of assistance so they can use the 'surplus' allocation of funds from one client with apparently lower needs to supplement the shortfalls in funding of the higher dependency clients.

While the package programs have guidelines and service boundaries in their frameworks, the application of the programs by service providers showed that in practice, there is no natural 'division' were the different packaged care program types would apply. Rather service providers responded by varying the hours of service provided within a program (with a large number of HACC clients receiving a level of service equivalent to package care clients and 54% use three or more different services) even though each client within a program was assessed as eligible for that program and was supposedly within a similar 'band' of need for support. These findings and feedback from consultations, and recent reviews (Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs; Inquiry into Caring for Older Australians) support the notion that the structure of high level community care programs into distinct package service types, in particular the CACPs, EACH and EACH-D programs, requires review as conceptually and practically the package concept may not be the most effective model for targeting high care needs clients living in the community.

Moving to a more integrated Aged Care Framework and Funding System

Warwick Bruen² indicated the priorities for the future of community care as among other things, being an expansion of community based aged care, increased consumer choice, improvement of coordination across sector boundaries and the more effective management of dementia. The Who Cares Report³ also draws attention to the vast and often not fully supported contribution to care

² Aged Care in Australia: Past present and future. Australasian J on Ageing vol 24 no 3 pp130-133 Sept 2005

³ *Who Cares? Report on the inquiry into better support for Carers*. Commonwealth of Australia. ISBN 978-0-642-79168-9.

made by unpaid, mainly family voluntary carers. It is therefore imperative that adequate support be built into the community care services for carers as they are reformed and developed.

It seems logical that there be a consolidated, transparent and universal system for the determination of funding based on assessed care needs for all high level aged care services whether they are provided in a residential environment or at a high level in community care settings. This approach is congruent with the proposed model presented in this report where the individual and carer's needs are the basis for service provision and determination of allocated funding. While an approach such as this will require significant changes to the way community care has traditionally been funded, any proposed approach that consolidates across high level programs must allow enough flexibility for types of consumer directed models to be possible at some future time.

New Model Considerations

Applied Aged Care Solutions have developed a model to fit the parameters discussed, and discussions were undertaken with a number of organisations and people who had submitted papers to the Productivity Commission's into 'Inquiry into Caring for Older Australians'. The consultations were limited in scope due to the report time-frames however efforts were made to include major participants in Aged Care to test the proposed model and incorporate their feedback to ensure the proposed model provided a suitable option to promote further discussion and refinement.

Summarising the background review outcomes from the literature and the consultations, the following points describe the considerations for the new aged care model:

- Nationally consistent information, assessment and classification approaches
- A single framework to provide a streamlined approach that would promote continuity of care, ageing in place (integration approach), simplified funding and accountability requirements
- Promotion of consumer choice, involvement and control
- Services to assist the special needs groups e.g. persons with dementia, younger persons with dementia, ATSI and CALD groups. Case management could be particularly important for these groups as well as for all clients with complex and high care needs to providing better co-ordination and enhanced consumer outcomes

- Extra services to include carer support services (respite, education, training, support), dementia related services but not singularly attached to the highest level of care; restorative services that focus on maximising functional ability; preventative approaches; home modifications; transport services; and supports to promote and maintain social interaction
- One program one funding framework will eliminate the significant gap in funding/subsidy between the CACPs, EACH and EACH-D packages
- Based on the clients care need assessment access to a comprehensive list of services for high level community care by removal of program silos that are created as clients move from one package type to another so they can access not only more care hours but perhaps different types of care support
- Inadequate subsidy for high cost care clients - particularly for short term illness or palliative care or post hospital care
- Inadequate subsidy for travel and rural/remote community aged care service provision
- Topping up across package programs with HACC services is viewed as putting excessive strain on the basic care tier HACC services potentially limiting services other clients depending only on basic HACC services
- The different cost to consumers for some services (when HACC services are bought in) is seen as unequitable
- Dementia or behaviour subsidies availability across all package types is viewed as desirable as challenging behaviours are reported across the all client types and care need levels
- The provision of information and assessment at centres connected with local services and service environments
- An external assessor and assessment pre-entry to the direct care environment or care provider provides a stronger basis for equitable resource allocation
- A common or standardised point for measuring care needs provides the best model to determine the most appropriate service system response to the care needs of the individual and family given the local knowledge of the service environment. It should be noted that the local service provider is however in the best position to conduct an 'assessment' to determine the preferences of the clients and carer and the appropriate service mix from the available resources
- A common or standardised point provides a workable approach for an accountability system (simplifying accountability requirements) as fewer, high skilled resources are involved in the decision making and funding determination

3. Preferred Model

3.1 INTRODUCTION

Taking into consideration the comments in the submissions and the directions provided by the Productivity Commission, AACCS developed a care system framework and assessment and classification model that would fit with the major themes previously discussed. Figure 3.1 presents the role and activities in the model, and Figure 3.2 presents the processes of the model. This chapter will discuss the model in detail.

Table 3.1: Description of Model Themes and Elements

Major themes	Model elements
National information and assessment model delivered via Regional Hubs	<p>The proposed model consists of a national information and assessment system with most if not all operational aspects provided and delivered at regional sites (hubs), using with a nationally consistent process that is defined by the following major functions:</p> <ul style="list-style-type: none"> - Contact (intake, triage, information provision) - Needs Identification (two assessment levels) - Planning (including goal setting) - Actions (referrals etc) - Service Provision (Lead Agency and Service Providers) - Review (evaluates outcomes incorporating a QA approach, supports clients being able to come in and out of the system, systematic, recognises client needs can vary and change over time)
<p>Continuity of care</p> <p>Seamless access to aged care</p> <p>Access to a wide range of services and programs (HACC, packages, residential care)</p> <p>Single aged care scheme</p>	<p>Consistent information and assessment that provides access to the full scope of community and residential care services and programs, and ability to provide most services in the desired consumer setting.</p> <p>Incorporating access to a range of aged care focussed programs under the one access- information; health promotion, early prevention; restorative/ rehabilitation (e.g. active and maintenance focussed); episodic programs (e.g. education and training, counselling); social inclusion programs (e.g. community transport, activities); nursing, continence, medication management, palliative care; domestic and personal care maintenance programs (e.g. general HACC type services); dementia/ mental health programs; carer supports/respite.</p>
Recognise the essential role of carers	It is recommended that if a Care Recipient is assessed that any associated (informal) primary carer also be assessed
Equity of outcomes	Nationally consistent information and assessment process
Recognition of consumer rights- delivery of consumer choice and control, focus on independence, self control, consumer driven care,	<p>Provision of nationally consistent information to inform consumers. Client included in process determinations e.g.</p> <ul style="list-style-type: none"> - self assessment option; - planning is client driven; - client can choose service type/service provider/setting within set

	<p>parameters (e.g. the plan must address the identified needs, the setting should meet OH&S requirements, a carer is available to assist the care recipient in the case of needs that could be met in a residential setting;</p> <ul style="list-style-type: none"> - client (or their broker) can elect to undertake service coordination and case management
Interconnect with health system	<p>Health system roles</p> <ul style="list-style-type: none"> - Complete part of needs identification (assessment) online for client; - Provides specialist assessment services when required;
Electronic records	<p>Process to have an electronic database support. Collection of information electronically Minimum data set (MDS) designed to meet the data requirements of all stakeholders</p>
Accurate and objective assessment Consistency in assessment Referrals based on assessed need	<p>Nationally consistent MDS Nationally consistent process (requires documentation, training etc). Needs Identification will screen across a broad scope of domains. The assessment process will provide a consistent set of information for all classification levels. The required information will include an identified care domain, a rating of the need, why assistance is required, and for some needs - carer supports available. There are two levels of assessment: (1) The first level of assessment has fewer and less complex identified needs. It has not been defined by the type of needs e.g. not defined by a select group of services, as there were many arguments for access being required to various types of services (including nursing) in small amounts. It will exclude a specialist assessment need. (2) The second level of the assessment covers all other (e.g. higher) levels of identified needs (more identified needs or needs requiring more supports).</p>
Assessment provides timely access to low level services	<p>This has been defined as low resource services. It does not reflect all current HACC users, but those who use few resources, and do not have complex needs.</p>
Assessment provides access to higher resource care packages e.g. packages of CACP, EACH and EACH-D	<p>The assessment identifies the needs (and therefore the scope of required services). In consultation with the client, the actual service delivery outline is defined (service types, service providers, setting). The plan is fitted around the identified client needs and goals; the client is not fitted into a pre defined package. One aged care program will remove the need for care packages as they are currently exist.</p>
Fits with a market approach and provides incentives for providers to improve quality and innovation	<p>Lead Agency Role</p> <ul style="list-style-type: none"> - Service coordination (when there are multiple service providers) - Case management - May have a service provision role <p>Broker could act on behalf of client or client could undertake:</p> <ul style="list-style-type: none"> - Service coordination - Case management
Assessment provides access to a full range of services	<p>The assessment will inform on the required data input for the classification model, which will produce a small number of funded levels</p> <ul style="list-style-type: none"> - Three low resource packages - 4 or 6 higher resource packages

Fig 3.1: Roles and Activities

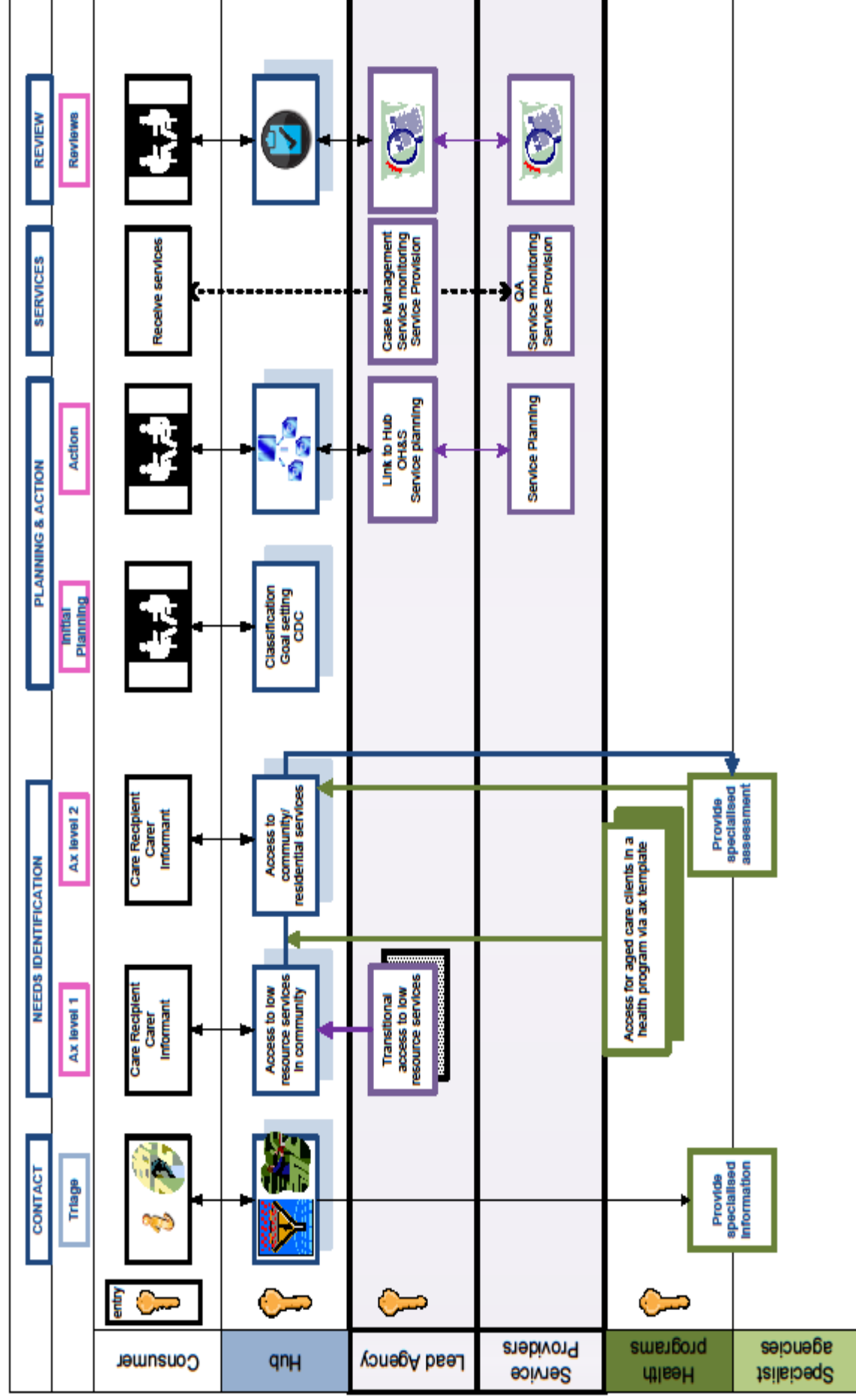
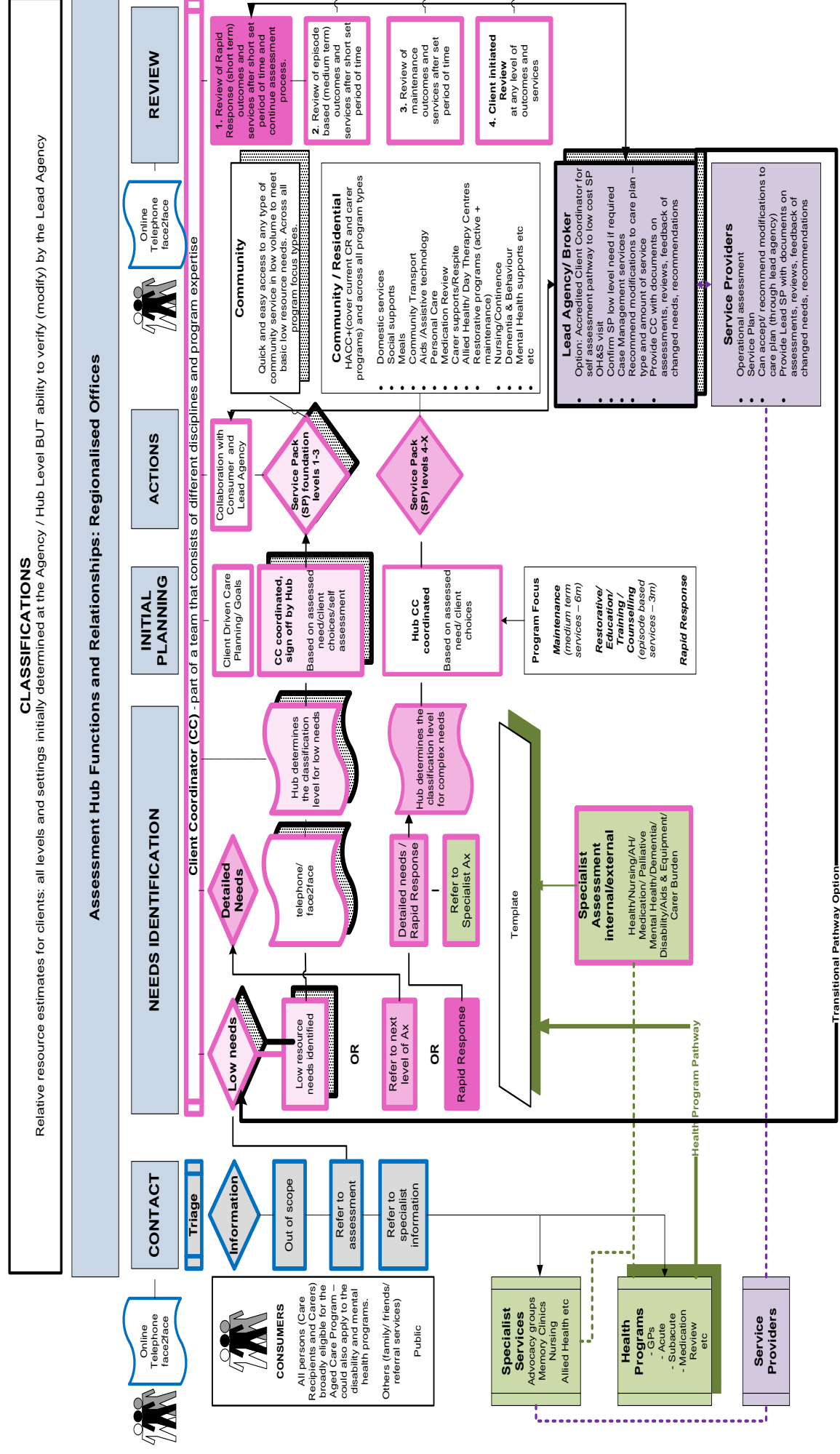


Fig 3.2: Processes Map



3.2 ROLES

This section will briefly discuss the four main types of participants in the model (refer to Figure 3.1 and Figure 3.2). The interaction pathways of the roles within the model are discussed further in the 'Process Description' section:

- Consumers who access the aged care system;
- The Hub is the regional office that provides information, assessment and coordination for the consumers;
- External agencies and systems that provide referrals into the aged care system and/ or provide specialist information;
- Service Providers for the aged care system

3.2.1 Consumers

The consumers are:

- i. The general public – may be enquiring about any general aspect of the aged care system. For example how to gain entry to the aged care system, what services are provided, who provides the services, what planning is involved. The outcomes for this group are the provision of information (or referral to an appropriate service). This group would also include services that provide for aged care clients that have a general information request.
- ii. All persons who are broadly eligible for Aged Care programs, this includes (potential or current clients) Care Recipients and Carers. They may have the same enquiries as the general public or request more specific information related to their situation. The outcomes for this group may include more than information, it may include assessment for services and the coordination through to the receiving of services and review of those services.
- iii. Others - these could be people or organisations associated to (potential or current clients) Care Recipients or Carers, who are enquiring about some aspect of the system on behalf of the (potential or current clients) Care Recipients or Carers.

3.2.2 Aged Care Assessment Agency & Information and Assessment Hubs

The Aged Care Assessment Agency would provide oversight of the national aged care assessment programs. The hubs are the regional operational arms providing the nationally consistent information, assessment and management services. They would use nationally consistent standardised assessment tools and operate in a regional framework. They would be placed throughout Australia in all health regions and could operate either as (i) the operational outreach offices of a centrally based aged care agency or (ii) operate as an outreach offices of a jurisdictionally based aged care agency model using the nationally consistent tools and

systems. The aged care agency and hubs should have independence from the funding body and the service providers. The main roles of the hubs are:

- a. Triage
- b. Information Provision
- c. Management of Needs Identification
- d. Initial Care Planning including goal setting
- e. Actioning, coordination and monitoring of the Care Plan
- f. Provision of independent advocacy for the clients

Options for the relationship between the central agency and the hubs and the hubs and the service providers are discussed in chapter 6.

3.2.3 Service Providers

Two levels of Service Providers are identified in Figures 3.1 and 3.2. These are:

- i. The Lead Agency- this role would be undertaken by the agency that provides the majority of services (where multiple service providers are required to meet the client's needs); they would manage the required documentation and feedback from the other services, and communicate this information to the regional assessment hub. They would undertake the Occupational Health and Safety visit to cover all service provision agencies. They would provide the ongoing case management for the client. This role could possibly be fulfilled by a broker (not a service provider) that coordinates the service providers for the client.
- ii. This role is undertaken by the agencies that provide services to meet the client's needs as set out in the initial care plan. They would provide required documentation and feedback to the Lead Agency. They provide service planning, service monitoring and service provision for the client.

3.2.4 External Agencies/ Systems

Two external bodies are identified in Figures 3.1 and 3.2. These are:

- i. Health system: This consists generally of health programs (not aged specific) that aged care clients may be in contact with or require the services from such as General Practitioners, acute hospitals, sub acute system, pharmaceutical programs such as medication reviews. These have been identified as possible sources of referrals to the assessment hubs.
- ii. Specialist agencies: These are organisations and services that specialise in aged care programs; they may provide information, education and training, services or advocacy in specific aspects. Examples are Alzheimer's Australia, Carers Australia, Memory Clinics, other advocacy groups etc. The

assessment hub may refer consumers to them for the provision of more specialised information; they may refer clients (Care Recipients and Carers) to them for specialised assessment as part of level two assessments (described previously).

3.3 FUNCTIONS

This section will briefly discuss the functions in the model (refer to Figure 3.1 and Figure 3.2).

3.3.1 Triage

Consumers make contact with the Hub. The purpose of triage is to determine if the consumer has contacted the correct agency, then if they require information or assessment.

3.3.2 Needs Identification

This phase involves two assessment functions.

- i. Assessment level one - involves a broad screening to identify potential areas of need and an assessment of simple or low resource needs. The assessment depth is determined by the classification model e.g. it must inform in enough detail to provide the classification criteria. This level provides for access to low resource services in the community.
- ii. Assessment level two - involves a broader follow-up assessment of the identified needs, there will be more domains triggered (compared to level one) or particular domains triggered, and the cases will be more complex. It will be more detailed and provide information across more domains than the first assessment level.

It should be noted that needs identification using these two levels of assessment is methodologically different to dividing needs into those met by HACC type services or residential services, and then considering only clients requiring residential types services need a complex assessment. Many current HACC clients currently receive comprehensive assessment and have complex needs. To develop a model that will provide a single aged care program and provide options in the service setting it will require a modified approach to assessment.

This assessment does not have to develop the service plan (which is best suited with a face to face assessment), but it does need to be conducted by assessors skilled in many domains of care needs typical of aged persons. There will be times when the identification of needs is best done face to face (e.g. special needs groups). The level of assessment skill required will be suited to an assessor of high skill. Otherwise

there is a risk of the first level assessment not being completed correctly. This will result in either too many clients receiving detailed assessments or alternatively clients missing out on the identification of their care needs. While this model has considered risk mitigation strategies (e.g. the feedback loop from the Lead Agency to the Hub) for the most efficient use of resources it would be best managed by the correct identification of needs at the entry point.

3.3.3 Planning & Action

The functions of this phase are:

- i. Initial planning between the consumer and the hub regarding how to meet their assessed needs. It should be a consumer driven and led approach unless the consumer requests for more assistance in the planning phase. This would involve defining the classification outcome of the assessment and any co-payment requirements, investigating the client goals and how they might be met. This is then developed into the initial care plan where the client can determine the service types, service provider/s and setting of the service delivery (where appropriate).
- ii. Action activities will activate the plan, such as the purchase services from service providers, selection of a Lead Agency where required. If required the hub will coordinate with the Service Providers on behalf of the client. Alternatively the client could undertake this activity themselves or with the assistance of a broker.

3.3.4 Service

The function of service delivery is to initiate the Care Plan. The Lead Agency (or broker) will provide the Service Plans and service assessments to the hub, the hub can then monitor that the planned services meet the assessed care needs.

The client can call on the hub during service provision to provide independent advocacy at any time. The Lead Agency can provide the case management role if required. Service Providers are expected to undertake service monitoring as part of their Quality Assurance activities.

Service use data could be collected by service providers to allow the hub to monitor the service provision.

3.3.5 Review

The review is a Quality Assurance activity and is undertaken by the hub. The hub will undertake formal reviews of the client needs, the service provision (timeliness, quality etc) and the progress towards the

client's goals. The frequency of the reviews will depend on the program focus or via a request from the Service Provider or the client.

Services put in quickly to meet an urgent need (e.g. rapid response), should be revisited after two weeks, to complete the assessment phase. Episodic services should be reviewed after 1 to 6 months (depending on the length of the episode). Long term maintenance services should be reviewed after 6 to 12 months (to be determined).

3.4 MODEL PROCESS

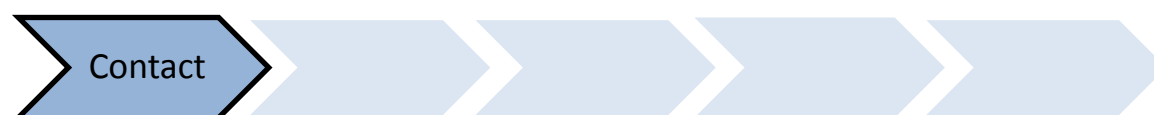
The proposed model is designed around (refer to Figure 3.2) the following:

- Phases - these are the major stages of the model;
- Functions - these are major groupings of activities.

This section will discuss in further detail the interaction between the roles, functions and activities in the proposed model. The model process is discussed under the headings of the five phases of the model –

1.Contact 2.Needs Identification 3. Planning & Action 4.Services and 5.Review.

3.4.1 Contact Phase



Currently

- Consumers can make contact to multiple services to gain information and access aged care services (e.g. ACAT, CRCC, individual HACC Service Providers, Carelink, Access Points, advocacy services, specialist services etc). The contact mode is usually via telephone or face to face mode, the information is not coordinated, nationally consistent or necessarily comprehensive (e.g. it may be service specific)
- Potential clients may need to make contact with multiple services to receive all of the required information
- Consumers may only be informed about services that they identify, or that the agency provides or is aware of. The current system does not ensure equity of access to information

Proposed contact process

- Hubs provide nationally consistent information and offer a nationally consistent process for access to their services
- Multiple modes of contact for information provision (online, telephone and face to face).
- Regional hubs will develop local knowledge
- Potential clients only need to contact a single point to receive equitable access to comprehensive information

Roles

The contact phase involves the hub and the consumers. The consumer may be a:

- Member of the public requesting information about the aged care system
- Care Recipient or Carer requesting access to services e.g. a client
- Other person enquiring about access to services on behalf of a Care Recipient or Carer

The hub will be a regionally located site to facilitate face to face contact with consumers, and to develop local knowledge that is shared with the Aged Care Assessment Agency. The hub should have access to the full range of national information about aged care services to be on offer.

Function

Triage will filter out incorrect calls, or determine with the consumer the nature of the enquiry. They will then determine the next pathway for the consumer- information or assessment.

Modes

It may be via online, telephone or face to face interview.

Purpose

For the consumer the process and the equity of the outcomes will not differ between the regional hubs. They will operate the same processes, access the same central information and determine pathways using the same decision support systems. The regional hubs may have more local knowledge to assist the consumer. The purpose of providing information is to inform and to support quality consumer directed choice. A consistent, accurate information layer will provide the base tools for the consumer to direct the outcomes

Description

Triage Process

This involves identifying the nature of the enquiry; it may involve a problem solving approach with the consumer, as the consumer may not be aware of what is available or what they may actually need.

The skill level and time required to undertake this activity should not be underestimated. It is important that appropriately qualified and experienced resources are used at this point in the model to get the process right. While providing an easy pathway to low intensity services is important, the time spent at this point should not be the focus of the purpose. It is better to spend time early in the process to explore the situation to ensure the consumer's needs are properly identified and then the consumer can be better informed.

The on-line mode should provide access to triage through a set of short questions, with information and the first assessment level being accessible on line. When triggered, the potential client should be given an option to complete the first assessment level on line or to be contacted by the hub. This will be discussed further in the Needs Identification phase.

The possible outcomes of this process are:

- Out of scope enquiry
- Information Provision
 - Provide nationally consistent information about the aged care system
 - Provide local information about the aged care system
 - Refer to specialist service (external to hub) for specialised information
- Refer to the Needs Identification Phase (for assessment level one)

Pathway to Information Provision

The triage process will identify that the consumer enquiry is best met by the provision of information. The consumer is provided with information (written information materials are provided, mailed out, emailed, faxed etc). For detailed information, for example on dementia issues, the consumer may be referred out to a specialist agency such as Alzheimer's Australia or onto a memory clinic for more specific information. All consumers are eligible to receive information provision.

Pathway to Needs identification

The triage process can refer the potential client (Care Recipient or Carer or their informant) to the assessment function of the hub if they have identified a request for or a potential need for aged care services. Assessment is a continuous practice undertaken for different purposes in different ways along the

various points of the pathway. At this stage in the model it is only the identification of a potential need for assessment for services that is required. Broad eligibility to the aged care programs and services should also be considered at this stage.

3.4.2 Needs Identification Phase



Currently

- Currently carers' needs are not consistently identified or assessed, they will often access information through different agencies to those that are assessing or servicing the care recipient. This current approach adds to the assessment burden and does not jointly consider the Care Recipient and the Carer.
- Quick access to community care services is practised, but the process is not consistently applied, resulting in a lack of equity of outcomes for consumers.
- Currently community care programs give access priority (e.g. Rapid response) in an ad hoc manner that differs between similar service types, resulting in a lack of consistency for clients. Clients may need priority access to particular services due to unplanned episodes (e.g. carer has an unplanned hospital admission and needs respite) or due to a build of stressful situations (e.g. client has made contact when the situation has become unbearable).
- Currently the assessment process is not consistent in the breadth of domains or the depth of investigation and information collected. Therefore the current practices do not produce a standard robust set of data that can be easily shared with other assessors, agencies or governments, and this means the clients are at risk of multiple assessments and possibly a prolonged interval between initial request for services and receiving the required services. It also means that decisions are not consistently based on the same type of information, resulting in a lack of equity of outcomes for clients.

Proposed Needs Identification

- Will jointly consider the Care Recipient and the Carer needs
- Nationally consistent broad entry assessment, which will trigger to a further assessment when required
- Easy access to low resource services with risk management practices to check for unmet needs
- Rapid response pathway (for urgent needs) with risk management practices to follow up with the client
- Integrated assessment using skilled assessors, to undertake a standardised detailed assessment
- Assessment co-ordination with specialist assessment services to complete the detailed assessment
- Assessment details will provide enough information for a relative resource estimate classification system
- Pathway to ensure access for clients to the hub from the external health system, into the Needs Identification process

Roles

The needs identification phase potentially involves:

- (i) the hub and potential clients or their informants
- (ii) the external health system and the potential client

Functions

This phase involves two assessment functions:

- (i) Assessment level one - involves a broad screening to identify potential areas of need and an assessment of simple or low resource needs. The assessment depth will be determined by the classification model e.g. it must inform in enough detail to provide the classification criteria. This level provides access to low resource services in the community.
- (ii) Assessment level two - involves a broader follow-up assessment of the identified needs, there will be more domains triggered (compared to level one) or particular domains triggered, the cases will be more complex. It will take longer and provide information across more domains than the first assessment level.

Modes

The client can complete assessment level one via any mode, however assessment level two should be via telephone or face to face mode, due to the more complex nature of the client's needs.

Entry

In the first option (where the client contacts the hub) the potential client/informant will have:

- (i) Made contact via telephone or face to face for the contact phase and will have been triaged to the assessment pathway; or
- (ii) Will have self elected to complete assessment level one on-line

In the second option the first access by the potential client to the needs identification phase is via the external health system. In this case:

- (i) The external health system would complete the first assessment level for quick access to low resource services. The case would then be taken up by the hub for checking that the assessment phase is completed. The outcome of the Needs Identification would be determined by the hub.
- (ii) The external health system would complete the first assessment level and relevant sections of the second assessment level (relevant to their expertise). The case would then be taken up by the hub for checking that the assessment phase is completed or the hub would contact the client to complete the assessment phase. The outcome of the Needs Identification would be determined by the hub.

Purpose

- Broadly identify needs
- Identify emerging needs that could potentially be addressed with a public health promotion, preventative approach or restorative program
- Identify unmet needs
- Identify low resource service needs for provision in community settings
- Identify service needs for provision in community or residential services
- Produce data for a classification system that will provide a relative resource estimate for service provision for all levels and in all settings

3.4.2.1 Assessment Level 1

Purpose

The purpose is to broadly identify needs including emerging needs, briefly describe the needs and provide the required information for the classification model. Assessment level one should provide easy access to the provision of low resource services in the community setting.

Entry Points/Modes

The consumer can access assessment level one:

- (i) On-line (self assessment); or
- (ii) By contacting the hub (telephone or face to face); or
- (iii) Via an external health system service (online)

Description

In assessment level one the assessor (or consumer) is required to firstly identify unmet needs at a broad level. This activity is often labelled 'screening' and it is the beginning of the assessment process. Screening reduces unnecessary assessment burden by only requesting information at a high level (e.g. domain level), then triggering to the next level of detailed assessment where required. The screening step should be comprehensive (in breadth) to cover a wide scope of potential and actual needs. It is important that it identifies current and 'emerging needs' to inform on health program supports, early prevention and restoration programs that might assist the client.

The second step is to answer a short set of questions about the client's situation to determine if the need is unmet and to what depth. The level of investigation (in assessment level one) will determine that an appropriate need has been identified and provide data for the classification level.

At this assessment level the minimum requirements will need to:

- Identify a need
- Identify emerging needs that could potentially be addressed with a public health promotion, preventative approach or restorative program
- Provide a trigger to the further assessment questions for low resource services
- Provide the further assessment questions
- Provide a trigger to a level two assessment when required (e.g. when particular domains or a number of domains are triggered)

The minimum data set should contain the following:

- The domains where need is requested/identified
- Completion of a care need rating when triggered- the rating may vary depending on the measurement requirement e.g. independent, emerging difficulty, occasional assistance, assistance all the time etc
- Identifying carer supports available (when triggered) – identifying formal and informal carers, what they do, their availability etc. This data set is only required when the care need involves the requirement of a carer for its completion
- Providing reasons why assistance is required

The difference between a level one and level two assessment is not necessarily the number of MDS items collected per domain but in the complexity of the assessment due to the consideration of multiple needs.

It is important that the decisions and outcome are based on a consistent set of information. Where an on-line tool has been completed the hub assessor will review the outcomes to determine the base information has been provided. All clients should be contacted by an assessor (telephone or face to face mode) at some point if they have triggered a care need.

The assessment process for any entry point should be consistent in the breadth of domains covered and in the data recorded. If a client self assesses (on-line) or has entry via the external health system, the hub assessor will contact those clients either at the assessment phase or the planning phase. The hub assessor will complete the assessment process or advance the case to the planning phase for low resource service packs or to the rapid response pathway. This will ensure that all classification determinations are based from a consistent information base and are managed by the hub.

All steps of the assessment phase should address both the carer and care recipient needs. Once a Care Recipient has been identified as requiring services, it is recommended that the carer be assessed also with a carer screening tool.

Assessor Requirements

The Needs Identification assessment (for both levels) is best suited to a highly trained assessor, such as currently seen in the ACAT or CRCC agencies. It does not require the assessor to be an expert in any one speciality, but does rely on a depth of understanding, knowledge and skill in assessment practices, older persons needs and aged care services.

They will require ongoing training and support. This role will involve a change from current practices and the importance of managing the change management aspect cannot be under estimated, as experienced in the Access Point Demonstration project which trialled a nationally consistent assessment process for community care services.

Services

1. **Clients with ‘emerging needs’** would be identified and provided with information about public health promotions and other preventative approaches where there are no subsidised service costs.

2. **Rapid Response Pathway**

The assessor can use their judgement to identify that a rapid response is needed. The pathway should include, at a minimum, a completed screen assessment. Then the assessor in direct contact with the client will complete the initial planning and action phases. This service is a stop gap approach to attend to a crisis or other urgent situation. A risk mitigation strategy is required to identify any other unmet needs or to continue the assessment in any previously identified (non urgent) domains; therefore a protocol is required to direct the assessment hub to return to the client within two weeks to complete the assessment phase.

3. **Low Resource Services Pathway**

There was an argument that the system should facilitate quick access to services that do not require an in depth comprehensive assessment to determine the client needs. The appropriate clients could be self identified (on-line), or identified by the hub through the assessment process, or through an external Health service or via Lead agencies as a transitional pathway. These service packs should only access low resource services provided in the community. There will need to be a transparency in the process to clearly demonstrate why the pathway and service pack was selected e.g. meals on wheels requested for a short term rehabilitation period, or assistance (with transport) is requested to access community social groups as the client has no personal or public transport options. The low resources service pathway and pack would be indicated as follows:

- a. Low Resource services as identified in assessment level one by the hub
- b. Consumer self assessment e.g. on line
- c. Low resource services with access from a Lead Agency.

In this scenario either the consumer has contacted a Lead Agency (from prior knowledge) or they are a current client and a service provider has identified a potential need.

In the last two scenarios, a strategy is required to monitor for any unidentified unmet needs.

The low resource pathway would have advantages and disadvantages that need to be considered along with possible management strategies (refer to Table 3.2).

Table 3.2: Low Resource Pathway

Advantages and Disadvantages	Strategies
<p>Quick access is facilitated. In a rapid response pathway, urgent services can be put in place and the client will return to the assessment phase in a set time frame. Reduces bottleneck for comprehensive assessment services. A small amount of community services has been demonstrated to be proactive in preventing unnecessary access to higher level services.</p>	<p>Fiscal or budget controls may be required to control demand. The model allows for regional budgets to be applied.</p> <p>Clear separation of boundaries between the health system programs (funded from the Health system) and Aged Care Programs (funded from the Aged Care programs).</p>
<p>Consumers can continue to access services through some known providers e.g. Lead Agencies.</p>	<p>Access through lead agencies could also be considered as a transitional process only.</p>
<p>Consumer directed 'self assessment' is enabled.</p>	<p>Requires risk management strategies to manage unmet needs. Consumers may not be aware of their needs. If unmet needs are ignored, there is the risk that a potential early prevention opportunity has been missed, or that a client is living at risk without understanding the consequences.</p>
<p>Separation of assessment and service provision is potentially corrupted</p>	<p>All entry points would use the same process, assessment tool and similar assessor skill sets. This could be managed by requiring that assessors (especially from the Lead Agency) become accredited by gaining a certified qualification.</p> <p>Requires oversight by the Assessment Hub:</p> <ul style="list-style-type: none"> ▪ Assessment Hub to sign off on the assessment outcomes. ▪ The client should not have complex or comprehensive needs. ▪ The assessor will contact the client (either face to face or via telephone) to check off these risks and provide a classification for the client (and information about any co-payment requirements). ▪ The hub will then undertake the Planning and Action phases.

Three possible options are discussed for determining which services could be provided in the provision of low resource services in the community setting.

1. There are low level community type services that are not dependent on identified care needs (based on health or disability impairments), but are supports that can help maintain any older person in the community:

- Community transport
- Meals on wheels
- Domestic services of cleaning
- Social inclusion

The access to these services could be based on eligibility rather than a detailed assessment of needs. Therefore they may also be more suited to a block funding approach.

2. There is a view that the type of service should not be limited but rather a small funding amount for any service/s should be allowed at the foundation classification level. This is because there could be circumstances where a small amount of a service could assist a client to stay in their community and prevent escalation of a health issue (and therefore possible entry to acute or eventually residential care).

3. The low level resource service packs would be based on a low IADL/ADL need profile. It would exclude access to specialist care supplements because the care supplements require a more advanced assessment approach as found in a level two assessment.

The data will provide enough information to understand basic care needs of the client and should have risk mitigation processes in place to check on any unidentified unmet needs and to monitor for client deterioration. All clients who receive a service will be visited by a Lead Agency that will undertake an initial OH&S on-site inspection. The Lead Agency role will be to coordinate Service Provider feedback to the Assessment Hub. The Lead Agency role is further described under 'reviews'.

3.4.2.2 Assessment Level 2

Purpose

The purpose of this assessment is to investigate triggered domains from the first assessment level. It will be in greater depth and cover more domains than in the first assessment level. The difference between a level one and level two assessment is not in the MDS collected but in the complexity of the assessment due to the consideration of multiple needs.

Mode

Telephone or Face to face interview.

Description

Completed for Care Recipients and Carers, to enable the joint consideration of their needs and reduce the assessment burden on the carer.

The depth of questioning collected is a match to the depth of the minimum data in the previous assessment level (e.g. domain, need rating, carer supports, reason for assistance). It will however be completed for more health domains and care needs. Assessors could complete a range of accredited tools (e.g. a toolbox) to fit with the special needs of the client (CALD, Aboriginal etc) or the interview mode, however they would complete a standardised set of data items for the MDS and to provide the required data for the classification system.

At this assessment level the minimum data requirements will provide:

- The same base minimum data set as collected in assessment level one
- Identify emerging needs that could potentially be addressed with a public health promotion, preventative approach or restorative program
- Provide the further assessment questions

Specialised assessments would also be used at this level to complete the assessment pack and to provide appropriate assessments for special needs groups.

Access to care supplements would be possible from this assessment level.

Specific eligibility may need to be considered further after a particular need has been identified but this will depend on the service to be provided and the different programs that the client may be eligible for (e.g. veterans have access to Veteran Home Care services and Carers have access to NRCP programs).

The hub should be staffed by a multidisciplinary team where possible, with a mixture of program expertise between the assessors. This may reduce the need for referring clients out of the hub for specialist assessment. However it is expected that there will be circumstances (e.g. rural remote) where the hub may have limited assessor skill sets to draw upon. The referral process to specialist services (to the health system or to the public sector) should assist in filling this gap, but should be coordinated by the hub assessor to reduce the complexity for the client and to maintain the independence of the assessment process and outcomes.

To maintain a flow for the consumer, the external assessment service will be requested to communicate about the assessment process and outcomes (e.g. assessment tools and care plans) they have undertaken to complete the standardised form. The standardised form (e.g. a template) will assist interoperability between the systems. This will allow for flexibility in assessment tools but will require the completion of a set of minimum data about the assessment outcomes and recommended actions. The hub will then complete the initial planning and action phase with the client.

Assessor Requirements

It is recommended that referral to external specialist services is made to complete assessment domains where the necessary in areas that require high level skills or where the assessor skills are not available in the hub. The Needs Identification assessment (across both levels) is best suited to a trained and qualified comprehensive assessor such as currently seen in the ACAT or CRCC agencies. It does not require the assessor to be an expert in any one speciality, but does rely on a depth of understanding, knowledge and skill in assessment practices, older persons needs and aged care services.

Services

The outcome of a level 2 assessment would provide for a wider range of resource service packs which could be provided in a community or residential setting.

1. Low Resource Pathway

This pathway enables access to low resource services in the community setting from assessment level one or two. The low resource service pack (with a foundation classification) only for services provided in the community) was discussed in assessment level one.

2. Full range of services

This pathway enables access to all types of services and can be provided in the community or residential settings after completion of assessment level two.

External health system pathway to needs identification

The external health system (e.g. GPs, the acute and subacute systems) may wish to refer a client to the Assessment Hub. The external health system can assist the client to complete a standardised form (template available online for all consumers). The purpose of the form is to reduce repeated assessments for the client; the external service does not have to complete all of the required information. This pathway can cover the full needs identification process.

Transitional Pathway from a Lead Agency

As a transitional consideration it may be suitable to allow clients to continue to make contact with the system through Service Providers (who are also Lead Agencies). This could be phased out after a set period of time. The Lead Agency would be required to have an accredited assessor to assist the client to complete the online assessment with the consumers. Options for this pathway are:

- (i) To only cover the level one assessment; or
- (ii) To cover the full needs identification process.

With either option an assessor from the hub would contact the client to confirm or complete the assessment information.

3.4.3 Planning & Action Phase



Currently

- Ad hoc consumer choice options
- Service provision can be potentially based on service availability
- Service Providers can capture clients from the initial contact phase and guide the assessment and care planning of services
- Ad hoc use of goal setting, depending on service focus

Proposed

- Consumer driven approach, consumer led approach, with back up options (the hub can provide service coordination) for clients who elect not to or cannot make these decisions
- The client can contract a broker to act in the Lead Agency role
- Service provision based on assessed need
- Goal setting to be included in planning activities
- Enabled Consumer directed care by providing information on options and choice in service types, service providers, setting (except for low resource package)
- Initial separation of planning from service provision

Roles

The hub and the client undertake the initial planning. The action function involves the service providers and potentially the broker option also.

Functions

- (i) Initial planning between the consumer and the hub regarding how to meet their assessed needs. Provider/s and setting of the service delivery (where appropriate).
- (ii) Action activities will activate the plan, such as the purchase services from service providers, electing a Lead Agency where required.

Purpose

Design and activate a 'consumer driven' care planning. It should be consumer focussed and driven with back up decision making options for consumers who cannot make these decisions or elect not to.

Description

The hub:

- Informs the client of the classification and any co payment requirements. The funded amount should include a set proportion to be used for administration (applies to all cases), service co-ordination (the case should meet a criteria such as requiring more than two service providers) and case management (the case should meet a criteria such as level of complexity would be equivalent to the current entry into residential care)
- Completes goal setting with the client
- Develops an initial care plan with the client for selection of service types, service providers, setting
- Assists the client to select a Lead Agency (where required)
- Coordinates service purchasing (if requested by client)
- Participates in the determination of outcomes (with the client) of all contested care plans
- Communicates with Service Providers via the Lead Agency regarding ongoing service provision
- Receive documentation (service plan) from the Lead Agency to check that the services will meet the client's needs

The client:

- ◆ Is aware of the classification level and any co-payments
- Participates in goal setting
- Participates in care planning at the initial and ongoing phases with the hub and service providers
- Participates in the selection of a Lead Agency role (where required); the client elects themselves or their agent (broker) to carry out the main functions of this role, or the hub can assist the client in the selection of a Lead Agency from the Service Providers

The Lead Agency:

- Completes the Occupational Health and Safety visit to cover all service provision
- Completes a Service Provision function (this does not apply to the broker)

Service Providers:

- Can accept or reject the initial care plan as they develop an ongoing rapport with the client, they are in the best position to identify changed or unmet needs.
- Provides the Lead Agency with a standardised service assessment and other documentation to support any recommended modifications to the care plan.
- Completes a service provision assessment which (in consultation with the client) will specify further how the services are to be provided

Broker Option

The broker is an option to be considered for assisting the client make decisions regarding the actioning of the care plan in the selection of the service providers.

In the next phase (Service), the broker would also undertake the service coordination and case management functions. The broker would act on behalf of the client but would be independent of the hub or service providers in coordinating the services and completing any required case management functions.

This is an alternative to a Lead Agency. It would operate as if the client was selecting the broker as the Lead Agency, but would exclude any service provision by the broker. The primary benefit for the client would be the further enhancement of the consumer driven approach by providing more control for the consumer.

As mentioned previously the classification resource estimate should have a set proportion allowance for administration, service coordination and case management. The service coordination and case management allowances would fund the broker role where selected. It would be up to the broker to prove their value to the client in this approach. They would however need to be registered with the hub and agree to complete the functions (except for service provision) of the Lead Agency role as described, undertaking the same responsibilities.

The service coordination and case management functions therefore could be undertaken by one of three options:

- The client
- The client's agent (broker)
- A Lead Agency (being a service provider)

3.4.4 Service Phase



Currently

- Service provided often based on availability of services
- Service Providers are a major entry point in the HACC system
- Service Providers carry out ongoing monitoring and assessment of needs (no change)
- Service providers provide HACC MDS
- Packages provide case management
- Clients may be accessing multiple service providers for multiple programs e.g. EACH + HACC services

Proposed

- Service provision based on assessed need
- Service Providers will be referred clients from the hubs based on consumer choice
- Service Providers to carry out ongoing monitoring and assessment of needs, they can recommend changes to the Care Plan through the Lead Agency
- Lead Agency provides the role of the direct link to the hub
- Service providers will provide a MDS
- Role of Lead Agency/broker in service coordination and case management
- The central agency will provide coordinated access to multiple programs

Roles

This directly involves the Lead Agency/ Service Providers with the client, and the Hub is also communicating with Lead Agency.

Functions/ Purpose/Mode

Service Provider will deliver services (face to face) and complete ongoing monitoring as part of their quality assurance for their own service. This may also be used to inform the hub on any identified unmet needs. The Lead Agency would provide case management as required and coordination of service providers with the hub.

The Hub would play a role in receiving and analysing any feedback or further requests from the Lead Agency, they could also be called upon by the client to act as an advocate.

Description

The hub:

- Communicates with Service Providers via the Lead Agency (or broker) regarding ongoing service provision
- Receive documentation (service monitoring) from the Lead Agency

The client:

- May have elected to carry out the main functions of the Lead Agency role
- Receive services as per the care plan
- Receive service monitoring assessment from Service Providers
- The client can call on the hub during service provision to provide independent advocacy at any time.

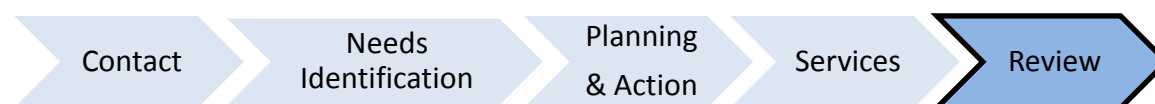
The Lead Agency or broker:

- Completes the function of Service Coordination when there are multiple agencies involved, this involves collating all required documentation from the Service Providers and providing it to the hub
- Completes the function of the Case management function where the case criteria has been met
- Completes a Service Provision function

Service Providers:

- Can accept or reject the initial care plan on an ongoing basis as they develop an ongoing rapport with the client, they are in the best position to identify changed or unmet needs
- Provides the Lead Agency with a standardised service assessment and other documentation to support any recommended modifications to the care plan
- Completes the service provision role
- Ongoing service monitoring and quality assurance activities for their service

3.4.5 Review Phase



Currently

- No nationally consistent review approach
- No measurable outcomes of the interventions
- Service Providers carry out the review (for their own service provision)

Proposed

- Nationally consistent review approach
- Goal setting will provide a consistent measurable outcome of the interventions
- Review timetable based on program focus
- Independent (of service provision) review
- Coordinated review of all services
- Hub assessor can act as an independent advocate for the client

Roles

The hub takes the central role, coordinating feedback from all participants such as service providers, Lead Agency and interviews or surveys with clients.

Functions

Evaluating client outcomes (goals) and the service delivery and also checking on the client's status.

Purpose

To evaluate that the services are being delivered as set out in the Care Plan and the service is of the expected quality. To evaluate progress on the client's goals and to check on the client's status. The review also completes a quality assurance activity.

Modes

This could be completed by multiple modes (receiving data, surveys provided on-line or mailed out, interview by phone or face to face etc). The mode will be determined by the hub as required.

Description

The hub will undertake formal reviews of the client needs, the service provision (timeliness, quality etc) and the progress towards the client's goals. The frequency of the reviews will depend on the program focus or via a direct request from the Service Provider or the client.

Services put in quickly to meet an urgent need (e.g. rapid response), should be revisited after two weeks, to complete the assessment phase. Episodic services should be reviewed after 1 to 6 months (depending on the length of the episode). Long term maintenance services should be reviewed after 6 to 12 months (to be determined).

The review should cover:

1. Documentation e.g. the client information on file, all service plans and assessments and any other service provider feedback
2. Service outcome surveys or interviews with all participants e.g. clients, carers, service provides, Lead Agencies or brokers
3. Discussions with the client about goal attainment
4. Checking with the client about their status e.g. changed, new or unmet current needs

4: Developing the Classification and Measurement Approach

The approach has two major components:

- Classification aspect e.g. the number of funding levels/categories/boxes
- Measurement aspect e.g. the assessment principles, purpose, target populations, users, tools, MDS, scales, algorithms, methods and statistical analysis

Whatever classification model is adopted a MDS will provide valuable information for many stakeholders. The MDS will cover area such as individual care outcomes, service management and program monitoring information.

It is strongly recommended that any model is underpinned by a single reliable measurement approach and that the measurement model guides to a large extent the actual 'classification' or final grouping or program type that the client receives.

A nationally consistent assessment approach and tool completed at a common or central point in the aged care system (e.g. regional hub) is considered crucial to the working of this classification model. The measurement aspect must be undertaken accurately and include an understanding of the responsibility of outcomes to the overall system and to the client. This will assist in strengthening the consistency and therefore equity of outcomes for clients as the process will directly involve clinical and care decisions that will ultimately result in a resource determination.

It is recommended that the actual care provider (the Lead Agency if more than one service provider) collaborate with the regional hub to determine the type and level of the actual care provided in consultation with the clients (e.g. care recipient and carer). If the assessment hub directs the client to an appropriate service provider (e.g. a person with a need for dementia care support is referred to a service provider with expertise in this area), the hub should be formally informed of the service plan and provision. This would ensure that there is a degree of congruence between the assessed care need at the assessment hub and the actual care provided at the service provider level.

4.1 CLASSIFICATION FUNDAMENTALS

The classification approach should adequately address the following specific principles as expressed in the submissions:-

- Classification and care services based on assessed need
- Provision of a 'continuous single care scheme' for aged care
- Provision of a 'seamless continuum of care' and improved ageing in place
- Address the current 'gaps' in the system e.g. abolish the need for clients to access multiple packages to have their needs met
- Support preventative, restorative, social inclusion, healthy ageing models
- Support consumer right to choices in services, service providers and settings
- Support equity and transparency for consumers with standardised assessment and funding
- Development of a more flexible system whereby service/package boundaries would not impact on client care
- Supports both the carer recipient and carer needs
- Cater for special need groups
- Informs on subsidised service co-payments
- Includes incentives for providers to improve quality of services and independence for clients

As is the case with the funding system in residential aged care it may be preferable to also develop an overall aged care funding system that provide identifiable "case types". These case types should be then associated with the funding provided. New aged care funding models will therefore allow description (at an appropriate level of detail) of individuals into meaningful 'care type' categories such as personal care needs, behaviour care needs and health/nursing care needs and this case type will then have an associated funding allocation.

Is the basis for the payment relativities methodologically sound?

The current funding relativities in the high level community care programs are based around residential care equivalents – High (with behaviour supplement) for EACH-D, High for EACH and Low for the CACPs. However there is no empirical relationship that suggests there is a 'cost' equivalence between a person with a particular assessed care need being supported by a high level community care program (e.g. EACH person) and the equivalent person (a person with similar assessed care needs) in a residential care environment. The funding and care need relativities between a high level community care program person and the residential care 'equivalent' person have not been established nor have the absolute cost differentials (a more difficult

task). Rather the relativities (of the recommended funding model) have been based on a determination that the funding provided at a particular level in a residential environment should probably be sufficient to support a high care need person (e.g. EACH program recipient) in the community.

In a new classification model there are three possible options to calibrate the various approaches.

Firstly if a level of community care that is intermediate to CACPs and EACH/EACH-D is adopted, a simple funding mid-point could be used. However this approach, while having simple appeal lacks any underlying theoretical basis (e.g. we don't know the type of client that will receive the funding – i.e. will the funding be provided to a person who has an assessed care need or requirement that is objectively intermediate?; there is also no way of assessing if the funding is sufficient, excessive or insufficient for the intended purpose). At present there is significant overlap between the care needs and care hours provided for EACH and CACPs clients and a funding mid-point may not ultimately solve the problem raised by the submissions to the previous Review of Subsidies and Services.

Secondly the classification model could be calibrated against the available funding with a reference point to the current funding relativities. In this approach the characteristics of clients would be linked to the current averaged variable costs of individuals (this is a constrained approach as services operate within the current funding allocations) to ascertain the relationship in the current system between care needs (in a range of assessed care need dimensions to be determined) and service hours, service types and costs. The available funding would then be calibrated to the assessed care needs relativities. This is not a model that uses 'real' costs as it is calibrated against the cost of the current services provided ('actual' costs').

Thirdly, cost relativities could be determined on the basis of standard cost models or 'care packs' (e.g. for an assessed care need level in IADL/ADL, behaviour, nursing, respite etc what would be the standard or typical resources required to provide quality care provision and services - this should be the costs of good care as defined in a care pathway). This will enable the relativities to be more accurately related to the assessed care needs as standard care costs may change due to a variety of factors in future, including better definitions of good care as defined in care pathways.

4.2 MEASUREMENT FUNDAMENTALS

The measurement approach should adequately address the following specific principles as expressed in the submissions:-

- Support equity and transparency for consumers with a standardised assessment approach
- Standardised data collection based on evidence based assessment tool or toolbox
- Provides robust objective data
- Based on care needed, not care provided
- Assessment undertaken independent of the service provision
- Electronic data that is useful for multiple stakeholders
- Incorporates early identification e.g. supports preventative and healthy ageing models
- Assesses both carer recipient and carer needs separately and co-jointly
- Process that identifies triggers areas that require further assessment
- Simpler assessment process that provides quick access to low level community services
- Assessment and care planning process that includes consumer driven choice, care coordination and care advocacy

The Measurement Model and approach operates independently of the type of Classification Model selected.

The assessment outcomes however should provide an algorithm that directs the assessor to a particular program type or classification level within whatever Classification Model is preferred.

While there are a number of viable options in terms of the Classification Models, the measurement model should be based around assessments focusing on care needs, not care provided and they should assess a set of attributes that are largely context independent, allowing for the assessment to be conducted outside of the specific context of the care. To carry out this type of assessment requires knowledge across a broad range of domains, inclusive of special need groups issues, and is therefore suited to a multidisciplinary team approach.

The approach is primarily focused on a person's attributes and need for care that could be determined from an assessment (outside the service provider context) that could then be used to determine funding relativities. The advantage with this approach is that the assessment (primary) is then done by the most highly trained group (generally), it can be done centrally, external to the care environment and provider (context independent) and it can determine relative funding without the confounding of the care provided context (e.g. person A has assessment level 3 but in EACH Program A gets 4 hours of type X care but in EACH Program B the exact same type of person gets 2 hours of type Y care – once we fund on the basis of the type of care provided as assessed by the service provider, there is no consistency or relativity). Being completed

at a central entry point (e.g. hub) also simplifies the accountability and validity requirements as fewer and higher skilled resources are involved in the decision making and funding determination.

The assessment would be completed using standardised assessments completed by an assessor with the highest level of skills (e.g. ACAT). However, the data collection aspect should not dictate the assessment approach e.g. a natural conversation should be supported, not interviews structured entirely on the data items only.

The assessment will need to be designed to be accurate and reliable. The first assessment level may be completed on-line (e.g. self assessment), and is also accessible by assessment from an external organisation. To manage the risk of initial access from the different pathways it should be limited to access for low resources and with further validation of the need by the service provider. The second assessment level may be completed in either a telephone setting or face to face, and is completed by an assessor independent of the funding receivers (client and service providers). This aspect (along with the final resource determination sitting with the hub) will provide a stronger basis for equitable resource allocation.

While a face to face assessment is possible from the hub the overall approach for the second assessment outcomes needs to be accurate from the lowest denominator (e.g. telephone setting). The service provider role in client assessment is to complete a service assessment in a face to face setting and to carry out ongoing monitoring of the client's needs. The service provider will have the opportunity to develop an ongoing relationship with the client to better determine the care provided aspects, as they are in the best position to negotiate the local circumstances and determine client (care recipient and carer) needs and wants – and take account of the local services available in the community. The hub assessment is about the basic care need assessment areas (that are important to resource use) and it does not try to cover how the care is provided. This makes for a 'cleaner' model as then the care provided aspects (the how the person is cared for) can be validated by an audit model assessing service plans and care outcomes.

The electronic data should be useful for multiple stakeholders as it:

- Informs the consumer about their needs and available services
- Builds up a history (i.e. reduces multiple assessment)
- Can be accessed between systems and organisations (e.g. health and aged systems)
- Provides accurate minimum data set (MDS) for program monitoring
- Provides accurate data for assessing need and care planning
- Provides accurate data to help inform on care delivery for service providers

Status changes could be addressed via:

- Regular planned reviews, the time of review should be based on the type of program
- Regular planned feedback from the Service Provider
- Requested re- assessment in response to a deterioration or trauma, via the Service Provider or client/carer

4.3 MEASUREMENT & CLASSIFICATION ASSUMPTIONS

The following areas are highlighted as assumptions that underlie the assessment and classification approach.

1. There are a set of core client dependencies that are common across all current levels of Community Packages. These core dependencies underpin all levels of programs and should form the base funding and care platform of a single community care program stream. The core dependencies in the base level are:

- Instrumental Activities of Daily Living (IADL)
- Activities of Daily Living (ADL- mobility and personal care)

These core dependencies could be targeted for either short term or maintenance programs. For example short term restorative programs after the client and the assessor have investigated this option during the care planning phase. For higher dependency clients these supports are generally long-term maintenance programs and will gradually increase in intensity over the course of the clients care pathway.

2. That low amounts of community services can help maintain any older person in the community:

- Potentially small amounts of a service, identified by a limited number of needs in the IADL and ADL domains
- More commonly they will be services that provide
 - Community transport
 - Meals on wheels
 - Social inclusion
 - Domestic cleaning

3. The resources required to support a person (community or residential) will increase as an individual's care needs increase in a wide scope of domains:

- Instrumental Activities of Daily Living (IADL)
- Activities of Daily Living (ADL- mobility and personal care)
- Health
- Nursing
- Dementia/Behaviour/Mental Health

- Continence (aids & assessment)
- Rehabilitation (Allied Health, restorative programs)
- Service Management (service co-ordination and case management)

4. The domains outside of the core dependencies of IADL and ADL are not common across all clients but they have a high incidence, they place the person at extra risk of residential care, they generally require specific service models and the resource requirements cannot be determined in full from the core needs assessments in IADL and ADL areas (note: they are in part reflected in the core assessed care needs funding determination however it is only the additional funding requirement over and above the core funding amount that would be included in these areas). These areas should be funded via a supplement approach that specifically identifies these areas and includes probably two funding levels (low, high) per care need area.

Some of these care need areas may be shorter term (e.g. episodic in nature) and the requirement will vary in intensity over the course of the client's pathway. In these short term areas the supplement payment may be made contingent on a limited time period before expiry (e.g. 3 or 6 months).

The supplement layers would effectively represent the areas identified by the current 'specialist' high level community care programs such as EACH and EACH Dementia and other care specialities not common across the Package Programs. These needs would be identified in a level two assessment.

5. There are other areas of care need that are not directly related to a client's impairments or conditions (or it is unclear how effective a measurement model would be in identifying the relationships) but these areas also require support and resources to assist the client and carer. These areas are in general:

- Carer supports – counselling, information, advocacy
- Respite support
- Aids/Equipment/Home modification
- Special needs groups – Aboriginal and Torres Strait Islanders, CALD etc
- Rural / Remote costs

5. Classification Options

Funding classifications will be briefly described for four options. The preferred model will be discussed in more detail. While models 3 and 4 best meet the underlying principles and process model as previously discussed in this report, it is model 4 that is the most flexible.

5.1 INTRODUCTION

The four main classification model options are described as follows:

- **Model 1: Package ‘Gap’ Funding Model** – inclusion of an intermediate level package and retains current program target aspects
- **Model 2: Package Category Funding Model** – include Categories within an EACH/EACH-D combined program and retains current program target aspects
- **Model 3: Additive Funding Model** - ‘Sums’ care needs and categorises providing for a single community support program model
- **Model 4: Layered Funding Model** - ACFI Type that layers the care needs into clinically meaningful aspects and providing a single community support program model with current program specific areas included as ‘supplements’ to the base care need layer.

It should be noted that some of the disadvantages associated with these models can also be addressed by using a standardised measurement tool and/or changes to program policies rather than just the classification system (e.g. providing dementia specialist services for low ADL care persons).

The issues of concern are:

- Addressing gaps between packages and avoiding the current topping up of a package with HACC services and the associated extra costs to users
- Providing access to all services based on care needed
- Providing continuity of care (by reducing the need to change packages and possibly service providers as needs change)
- Addressing rural/remote travel and workforce costs
- Providing access to dementia specialist services for persons with low ADL needs (i.e. mobile with dementia or incontinent with dementia)

5.2 Model 1 - Package 'Gap' Funding Model

This approach includes an intermediate level package and retains current program target aspects. It provides a simple solution to the immediate issue of the 'gap' between the CACPs and EACH and EACH-D packages. This 'Intermediate Care' package would essentially be targeted between the current CACPs and EACH/EACH-D packages. While perhaps relatively straightforward to implement, this approach does not address the fundamental problems with the system and may fragment service delivery framework even further. It also does not address the alignment of care need to services provided or provide for an accountability framework to provide controls around the equitable distribution of funding.

Advantages

- Simple conceptually as a quick fix
- Provides another funding level although additional funding for this must be provided as there would be no option to rationalise the funding to the existing packages (e.g. can't reduce funding to EACH / EACH-D to pay for this additional commitment)

Disadvantages

- Difficult to define what care need 'gap' is being covered and if efficiencies would be improved.
- Probability that it would simply cover the same type of client from the existing CACPs packages as most clients in CACPs would eventually move up to this level.
- The fragmented package approach is maintained with boundaries preventing access to particular service types an individual may require on a short or medium term basis (this is where a client's change in condition may not be long term).
- Does not address continuity of care.
- May set-up another administrative level to manage the new 'program'.
- No case type evident from the classification groupings.
- Does not provide access to a full range services that may be required based on assessed need.
- Does not provide access to dementia specialist services for lower ADL care persons (mobile and physically fit).

5.3 Model 2 - Package 'Category' Funding Model

This approach includes categories within an EACH/EACH-D combined program and retains current program target aspects. It provides a solution based on the categorisation of the EACH and EACH-D Packages. Currently the adjusted program hours to clients has been found to vary significantly in practice for these packages. For example for the EACH program clients the variation was between 1 and 47 hours per week and for CACP clients the range was between 1 and 50 hours per week. Given that the EACH Packages have significantly more funding than CACPs packages, the variability in EACH program hours does suggest that an approach that categorised funding into levels for the EACH programs only would be sensible.

CACPs packages would remain as currently but the EACH and EACH-D packages would be 'merged' and three funding categories created based on the level of assessed care need. The three EACH funding categories could be aligned to EACH Low, EACH Medium and EACH High. The measurement model would be used to determine what category a client was eligible for as an outcome of the assessment process.

Advantages

- Simple conceptually and relatively easy to implement.
- The categorisation of EACH Packages into three funding levels would fit with the current practice adopted by service providers where they provide either a low or high level of service from the total package funding allocation based on their determination of relative need. An approach that determined the applicable level at the central assessment point would serve to create a fairer, more equitable approach.
- Removes the EACH Dementia package to enable dementia support to be provided at all package levels, not just at the level of high care equivalence.
- Would not set up a new administration level.

Disadvantages

- The fragmented package approach is maintained with boundaries preventing access to particular service types an individual may require on a short or medium term basis.
- Does not provide continuity of care for CACP clients (CACP clients may need to change service providers when needs increase).
- Does not provide access to a full range of services for CACP packages.
- Does not provide access to dementia specialist services for lower ADL care persons (mobile and physically fit)

- Service providers may feel they have lost some control and flexibility over funding and service allocations as they now have clients located in narrower funding bands than is currently the case
- No case type evident from the classification groupings

5.4 Model 3- Additive Funding Model

This approach effectively 'sums' care needs and categorises into funding levels based on relativities (as did the previous RCS funding model). In this model certain client and carer characteristics would need to be 'weighted' in a statistical model to provide the range of scores and associated funding. The approach would allow the provision of all service types but the amount and complexity of services would be limited by the available funding in the classification level. The Additive Funding Model approach is diagrammatically represented in Figure 5.1.

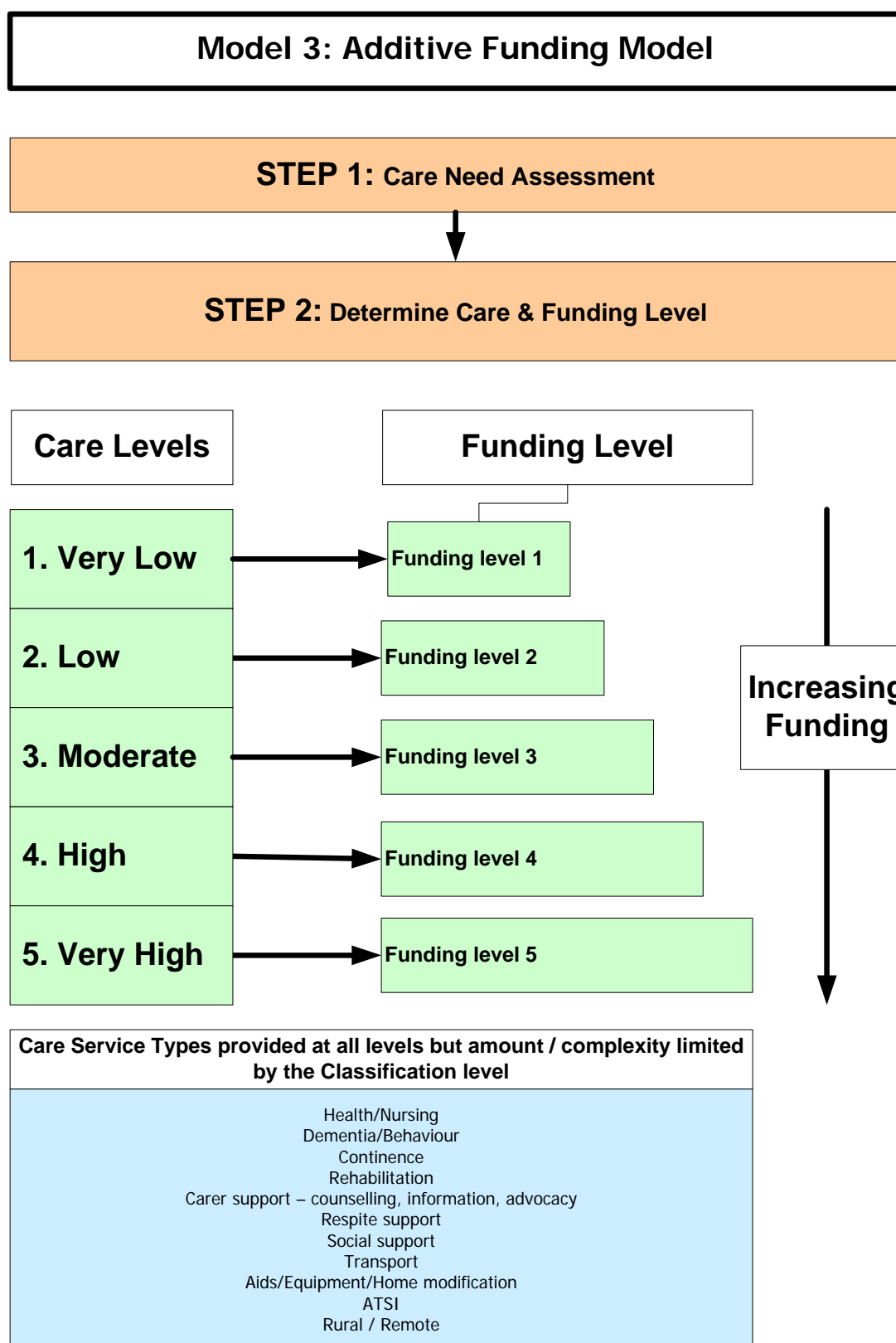
Advantages

- Provides an incremental approach based on assessed care need.
- Eliminates the Package 'gaps'.
- Fits the current practice adopted by service providers where they provide incremental increases in hours / services for their lower compared to higher care need clients.
- An approach that determined the applicable levels at the central assessment point would serve to create a fairer, more equitable approach as there would be a clear relationship established between a level of care need and an expected level of service provision.

Disadvantages

- It will be more difficult to articulate the funding provided for different aspects of care.
- The model is less flexible when it comes to making changes. For example changing/updating funding relativities is more difficult as the care need domains are not partitioned in the model.
- Service providers may feel they have lost some control and flexibility over funding and service allocations as they now have clients located in narrower funding bands than is currently the case.
- No case type evident from the classification groupings.
- Mixes personal, nursing and behavioural care needs into a single stream and removes the identification of specific care focus areas from the classification; it does not provide a match to the ACFI funding.

Figure 5.1: Additive Funding Model 3



5.5 Model 4 - Layered Funding Model

This is an ACFI type model that layers the care needs into clinically meaningful aspects and provides a single community support program model with current program specific areas included as 'supplements' to the base care need layer. This model effectively provides for a single aged care funding stream fundamentally different from the existing care package approaches. It addresses the gaps in the current system and provides a driver to better align assessed care needs to care provided. The Layered Funding Model approach is diagrammatically represented in Figure 5.2.

While the actual specifics of this model would only be finalised after further investigations and analysis it is suggested it would include three components:

- Low to very high levels of 'IADL and ADL needs';
- Layered 'supplements' covering specialist areas (e.g. dementia/behaviour/mental health, health/nursing/continence, palliative care, rehabilitation);
- 'Care support' needs (which could be pooled with all base and supplement combinations).

The proposed supplements are aligned to the current specialist high care programs (CACPS, EACH, EACH-D) but the funding that would be allocated will only be directed at the marginal 'cost' in these areas over and above what is already taken account of in these areas in the base layer payment. For example, a person with dementia may possibly have associated IADL and ADL impairments due to their inability to cognitively plan, sequence and perhaps identify the objects required to perform the task. The resource requirements in this area would be therefore included in any IADL/ADL assessment. However there may be additional care needs due to dementia in terms of behavioural or orientation care needs that are not included in the IADL/ADL care domain. These are the areas that would then be targeted in the supplement funding focusing on dementia specific care needs.

The model provides for a flexible combination of the three elements. The quick assessment pathway (assessment level one) is incorporated into the foundation layer funding in Figure 5.2 and would have criteria based on:

- Low IADL/ADL identified needs
- No identified care supplements
- A limited number of care support needs

A rapid response pathway also provides a quick pathway to services but includes a return to the assessment phase (in two weeks) to continue the assessment of needs. In the rapid response, services that meet

functional needs or care support needs could be provided. Service provision associated with care supplements would require the completion of assessment level two.

The low IADL/ADL levels is used to fund the lower cost service outcomes that are now typical of a large number of HACC system users. This is the foundation funding layer that provides a quick assessment pathway to low resource services. Further investigation would be required to determine specifically what level and mix of the 'care supports' would be included in the quick assessment pathway. For example these could cover restorative services, respite, transport, aids/equipment, social support, carer supports, rural/remote, ATSI. However, it may be preferable to provide block funding to organisations rather than providing individual allocation of funding for some of these supports.

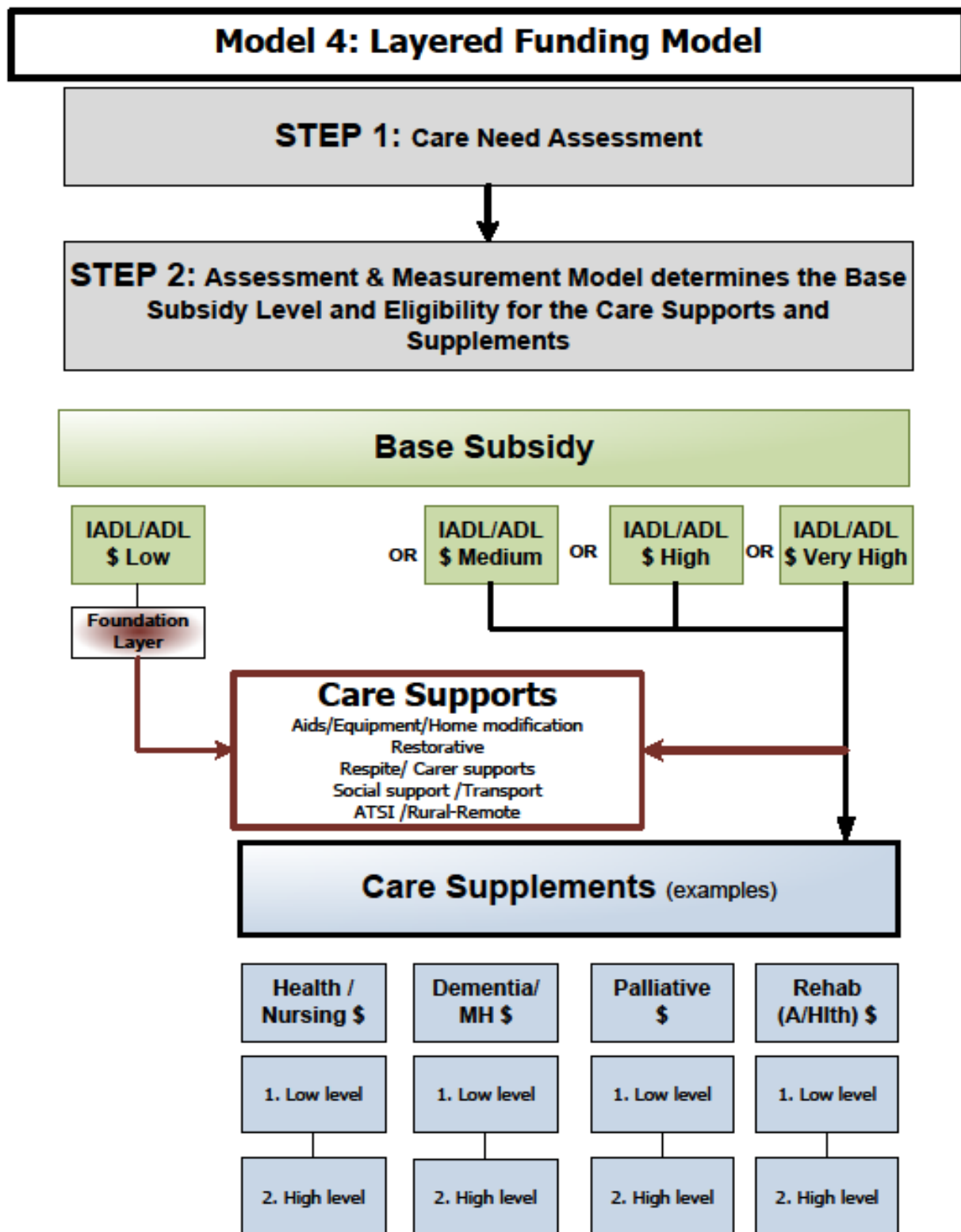
Advantages

- Eliminates the package approach where service types are constrained and instead focuses on what the client needs in a flexible and responsive way. A foundation care amount is provided and at any level special subsidies can be included to target key care need areas.
- Provides an incremental approach based on assessed care need and eliminates the Package 'gaps'.
- Fits the current practice adopted by service providers where they provide incremental increases in hours / services for their lower compared to higher care need clients.
- An approach that determined the applicable levels at the central assessment point would serve to create a fairer, more equitable approach as there would be a clear relationship established between a level of care need and an expected level of service provision.
- Provides for a clearly described case type.
- Allows service providers to consider the care needs as the primary consideration and not focus on fitting the package to the person (continuity of care approach with access to all services as required).

Disadvantages

- Service providers may feel they have lost some control and flexibility over funding and service allocations as they now have clients located in narrower funding bands than is currently the case.
- Will require a reliable standardised assessment to be completed at the hub assessment point.

Figure 5.2: Layered Funding Model 4



6. The Model in Operation

6.1 MEASUREMENT MODEL

The measurement design should ensure that the data is objective, can be recorded accurately by the users, and produces the required data for the classification model (refer to Figure 5.2: Model 4 Layered Funding Model).

Mode of assessment

The mode of the assessment must be taken into account when considering what data can be collected objectively. For example, capacity (e.g. what can you do) cannot be reliably determined via telephone mode. A capacity response may involve the client guessing because they have not previously carried out the task (e.g. meal preparation or house maintenance). To improve the objectivity, the response should be based on facts; therefore the question should ask 'what do you currently do'. The capacity type assessment is best in a face to face assessment (e.g. at service provision), and then it should be based on an agreed (standard) tool and be completed by an appropriately trained assessor.

Profiles, Domains and Items

The measurement model will provide information about care needs at the item level, which are individually rated. Items are grouped into clinically similar domains, and a group of domains are used to describe specific profiles of the client. Both the measurement and classification models use this layered approach (starting at the item level and working up the client profiles). Services will usually be provided at the profile level (e.g. health services, functional care needs) and the majority of a client's needs will preferably be provided by one service provider for a seamless approach for the client.

The functional item ratings are used to determine a number of domain ratings (e.g. low, medium, high or very high) using algorithms or business rules. The highest functional domain rating determines the Base Subsidy funding level. This is further discussed in section 6.2.

The Health, Psychosocial, Care Arrangements, Carer and Care Support profiles collect information that describes a comprehensive range of the client's needs and are utilised in the Care Support, Care Supplements and in the planning stages. The recommended assessment profiles and associated domains and items for both Care Recipients and Carers are provided in Table 6.1.

Table 6.1: Care Recipient and Carer Profiles

Profiles	Domains
Health Profile	Health conditions/status Medications Complex health Sensory/ Communication Rehabilitation
Functional Profile	Domestic Nutrition Living Skills Mobility Personal Care Continence
Psychosocial	Cognition Problem Wandering Verbal behaviour Physical Behaviour Mood/Depression
Care Arrangements	Formal and informal supports profile Services and resources used
Carer Profile	Carer profile Care Supports Carer health/functional needs triggered
Care supports	Aids, Equipment, Home modification Special needs groups Carer supports Respite needs Restorative needs Community transport Social Inclusion activities
Care Planning	Goal setting Consumer Directed Choice preferences
Referrals	Referrals for items and domains with priority
Reviews	Goal setting Service delivery Unmet needs

Scaled responses

Many item responses will be scaled or pre categorised, this will provide the type of data that can be systematically used to determine care needs, unmet needs, triggers, priorities etc. The developed scale responses will need to be supplemented with detailed instructions and definitional requirements as per the approach used with the ACFI tool. This is needed to ensure consistency of interpretation across users and instruments.

Emerging Difficulties

To help identify early intervention cases, it will be important that the functional scale include 'emerging difficulties'. Current HACC functional scales do not include this aspect. Therefore the functional rating scale could possibly be - Independent, Emerging difficulty, some assistance and full assistance (e.g. all the time).

Standard toolbox

The electronic data collection tool could be designed to collect a MDS, based on the use of a number of assessment instruments from a standard toolbox. The MDS would need to reflect what is required to determine the classification and the broad needs of the client. The data collection tool should be an IT tool (e.g. electronic records), it could also provide for assessor judgement to make changes to the recommended outcomes, within set boundaries e.g. limit the extent of changes allowed, assessors to record a standardised response to explain the reason for the recommended change. The recommended outcomes would be based on determined algorithms or business rules that guide the assessor's final selection.

The UK and New Zealand systems have set up processes and structures to develop a set of national assessment instruments that meet a set standard (e.g. fit to the purpose, target audience, user and outcomes required). However, it should be noted that both the UK and New Zealand do not have an algorithm approach for their classification, therefore the MDS is not as critical as it is in the proposed model of this paper. While a toolbox allows for special need groups to have access to an assessment process that fits their particular situation, it is however vital that the tools are able to generate the required MDS for the classification model. The assessment tools must meet the set criteria, not the MDS being reduced down to meet the outputs of the toolbox.

Standard sets of questions

Currently common MDS tools (e.g. HACC) only record the outcome of the care need rating (e.g. independent, emerging difficulty, some assistance, full assistance). However to deliver national consistency in care need ratings, a standard set of questions needs to be asked and a decision tree followed. The detailed steps provide the necessary information for an algorithm to provide the rating, otherwise the rating outcome remains possibly subjective and open to assessor bias. If the shorter MDS is chosen, the education and training component will need to focus in detail on areas like this, it should not be readily assumed that current practices reflect such a standardised approach.

The use of standard sets of questions can be fitted into a conversational style and interview guidelines can be developed to assist the assessor in this activity. The questions do not have to be directly asked, however

the assessor should be confident of the responses to the question set. Using a repeated, standard response set across multiple items reduces the complexity of recording the information for the assessor and increases the accuracy of the assessor's recorded response. Figure 6.1 provides a generic example of how to determine the care need rating of a functional profile item.

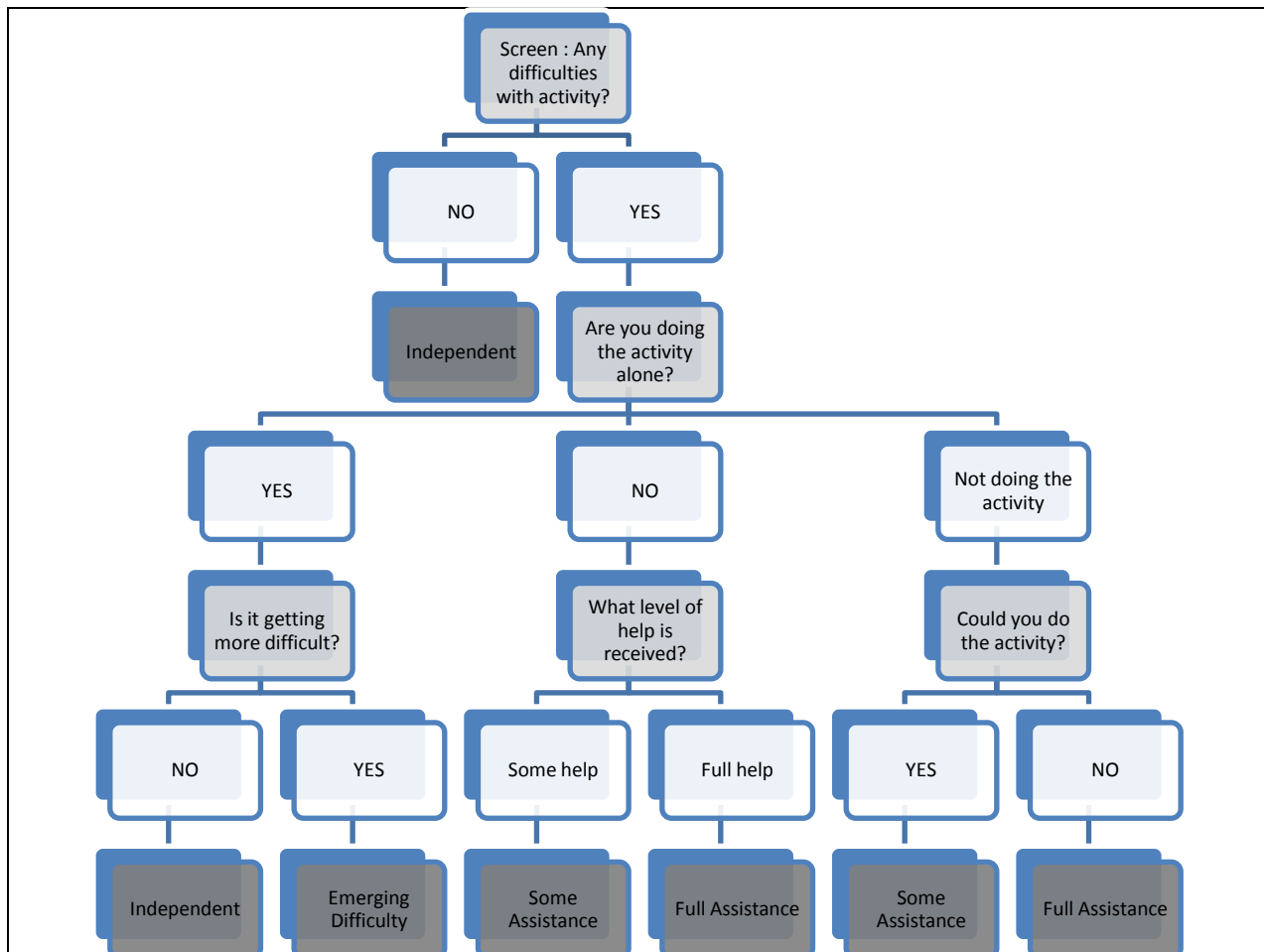


Figure 6.1: Determining the Care Need Rating of a Functional Profile Activity

Congruence

An item about 'reasons for assistance' should be collected to provide a check (for congruence) to the determined level of need recorded. That is, a person will have some identified reason for requiring assistance. The client's profile should make logical sense to the outcomes e.g. a person with moderate dementia will require some level of assistance for most functional items.

Triggers

Triggers in the assessment tool should:

- Be based on algorithms across items or business rules related to the responses within an item;
- Based on the identification of a need, open a set of questions to complete the MDS for that item;
- Provide information to support decision making;
- Identify clients eligible for low resource services;
- Recommend service referrals based on the identified needs;
- Recommend further assessment requirements;
- Recommend follow up review time lines

Priorities

The measurement model should incorporate a standardised method for determining priority as this will support those requiring support services as soon as possible. Priorities will be provided for individual care needs and across domains (refer to Table 6.2).

The determination of priorities may differ between domains depending on the type of data collected. Table 6.1 presents the priority determination for functional items. After the individual care need is identified, it is rated. In this case it involves a scaled response from an item rating (Table 6.1 column 1). In another domain it may occur directly from the assessment process (a present or absent outcome).

Then consideration is given for how fully the person's needs are met by formal and informal care (Table 6.1 columns 2, 3). This then informs the assessor on how to determine the overall unmet need status (Table 6.2 column 4). Additionally an indication of a recent deterioration (Table 6.1 column 5) then further informs the generation of the item priority by acting as a 'modifier' at the item level (Table 6.1 column 6).

Determining the overall domain need and the priority for a domain will assist the assessor in deciding which domain should take precedence for intervention (for example, if the domain need summary indicates high need but there is low priority, the inference is that the needs are currently being met and there has not been a recent deterioration).

In summary, a person may have a series of needs identified, a set of referrals (with priorities for service level assessment) associated with those needs (taking into account unmet need and recent deterioration) and also a summary of need/dependency in the domain and an assigned domain priorities (refer Table 6.1 column 8).

Table 6.2: Example of a Priority Model

Step 1.	Step 2.	Step 3.	Step 4.	Step 5.	Step 6.	Step 7.	Step 8.	Step 9.
Item Rating	Formal Support Provided	Carer Support Provided	Overall Need Met [using steps 2 and 3]	Recent deterioration	Priority for Item Level Referral then set from columns 1-5. e.g. the item is bathing	Domain need summary e.g. the Personal Care domain has a need scale comprised of a number of ADL items	Priority for Domain Level Referral e.g. overall personal care.	Referral / Service Type
(1) Independent (2) Emerging difficulty (3) Some Assistance (4) Full assistance	e.g. HACC services	Informal support e.g. do they have a carer, does the carer live with them, r do they live alone	Assessor Judgement of unmet need: Using previous items: (1) Completely met; (2) Partially met; (3)Not adequately met.	Has the problem become worse in the last 6 months?	This rating takes into account formal and informal support, unmet needs and recent deterioration.	This domain level scaled need summary is independent of any other factors such as the degree to which needs are met.	The Domain Priority takes into account formal and informal support, unmet needs and recent deterioration. It enables the Service Provider to look at the recommendation for an overall domain in contrast to a specific item in the domain (refer step 6).	For example, HACC service, nursing, comprehensive, health) Referral Rating: 1-No referral; 2- No referral but reassess in 3 months; 3-Yes provide referral If a referral is recommended, the priority is as follows: Referral Priority: (1) Low; (2) Medium; (3) High

6.2 CLASSIFICATION

The assessment outcome is determined by the hub assessor (or client coordinator) and the assessment provides the classification data. The actual specifics of this classification model are not finalised, it will require extensive data analysis to test the proposed model and select final decision points.

It is suggested the model would include three components as previously discussed:

- **Base subsidy** covering IADL and ADL items grouped into domains;
- Layered **Care supplements** covering specialist areas (e.g. dementia/behaviour/mental health, health/nursing/continence, palliative care, rehabilitation);
- **Care supports** which could be provided with all base and supplement combinations.

The classification model provides a flexible approach in the final determination of the three components.

6.2.1 Quick access to services

Assessment level one provides a quick assessment pathway to low resource services. This is the foundation layer funding as presented in Figure 5.2. The rationale for providing this pathway would be that a small amount of HACC type services assists to maintain clients in the setting of their choice. This foundation layer could provide up to three funding groupings to take into account a combination of low IADL/ADL needs and care supports.

The criteria for the foundation pathway would be the selection of a small number of low resource services based on:

- Low IADL/ADL needs (1 or 2)
- No identified care supplements
- A small number (1-2) care support needs

The rapid response pathway also provides for quick access to urgent services (not including care supplements).

Consideration needs to be given to the number of funding categories as there need to be enough categories to ensure there are appropriate incentives for the full range of high level community care clients to be identified and appropriately funded but not so many that it causes additional administrative overload.

The classification funding should also specifically provide for administration and coordination activities. In the model described, this funding aspect could be provided to the Lead Agency, the broker or the client. To avoid too much money being siphoned off for administration and co-ordination activities, it is recommended that the classification denomination (provided by the hub) have a set proportion allocated for:

- Administration (flat % for all cases)
- Co-ordination (possible criteria is when two or more services required)
- Case management (criteria to be developed based on the complexity of the needs e.g. equivalent to residential care eligibility)

6.2.2 Community aged care classification

The classification MDS would ideally be an instrument similar to the ACFI approach (refer to Appendix A) and will cover the items needed to determine funding for both the low and high level community care programs and potentially allow mapping to the residential care ACFI MDS items. This could enable an assessment to be completed at the hub to provide classification and funding allocation for community and residential care settings.

A Community assessment approach would:

- Provide a funding algorithm - this is not a comprehensive assessment of all care areas or all care needs of care recipients. It will include only those items that best discriminate the level of a care needs between care recipients/carers. Questions that would have a similar resource need for all care recipients are not required in a funding tool
- Fit into a more comprehensive care planning and quality assurance approach - to do this it needs to take into account the data items collected prior to this assessment point and after the assessment point (e.g. Service Providers completing a comprehensive assessment that is broad in the care domains covered and deep in content where appropriate)
- Be designed for the Australian setting, just as the ACFI is an Australian instrument designed for the particular needs of the Australian aged care environment
- Provide the basis of a strong accountability system by using independent assessors (i.e. not associated to the funded organisation), this decreases assessor bias

- Provide the basis of a strong accountability system by providing a MDS that is based on standardised and validated assessments not (subjective) documentation, thereby improving the objectiveness of the data collected
- Provide the basis of a strong accountability system by ensuring the data items are objective and reliable (i.e. same results from different assessors on the same cases) to improve assessment fairness, equity of outcomes, and assist in any required validation/audit needs

A community classification tool would need to cover the three different classification components - Base Subsidy, Care Supplements and Care Supports. Table 6.3 provides an overview of the assessment items and domains and how they fit into the classification model.

Table 6.3: Domains, Items and Model 4 Classification Components

Domain	Items	Base Subsidy		Care Supports	Care Supplement
		IADL	ADL		
DOMESTIC	Light Housework	✓			
	Heavy Housework	✓			
NUTRITION	Food Shopping	✓			
	Meal Preparation	✓			
	Eating/Drinking		✓		
LIVING SKILLS	Managing Finances	✓			
	Telephone Use	✓			
	Clothes shopping	✓			
	Medication Management	✓			
	Transport	✓		Transport	
	Social and community participation	✓		Social	
MOBILITY	Movement in bed: rolling supine to/from side lying		✓		
	Transfers: supine (on back) to/from sitting		✓		
	Transfers: sitting to/from standing		✓		
	Moving around the home- Locomotion/ambulation		✓		
	Use of stairs		✓		
	Getting in/out of shower		✓		

Domain	Items	Base Subsidy		Care Supports	Care Supplement
		IADL	ADL		
PERSONAL CARE	Toileting (exclude transfers)		✓		
	Dressing/undressing		✓		
	Washing self/bathing		✓		
	Grooming		✓		
CONTINENCE	Urinary continence		✓		Continence
	Bowel continence		✓		Continence
HEALTH	Medication				Nursing assistance
	Complex Health items (based on ACFI Q12)				Any item with unmet needs
	Health conditions and status;				Chronic Pain/ Palliative Care
	Sensory- vision, hearing			Aids	
	Communication			Aids	
REHABILITATION	Checklist				Rehabilitation
PSYCHOSOCIAL	Diagnosis Cognition Checklist Behaviour Checklist Depression Checklist				Dementia/ Behaviour
CARE ARRANGEMENTS	Formal and informal supports Care Arrangement checklist Service and resources used			Respite	
CARER	Carer profile checklist Carer needs checklist			Carer support	
CARE SUPPORTS	Aids/ equipment/ Home modifications Special Needs Groups Carer Supports Respite needs Restorative needs Community Transport Social inclusion activities			✓	

Base Subsidy

The Base Subsidy level consists of core functional dependency items common across all community care programs. It is expected that clients will require assistance in many aspects of their activities of daily life, covering both IADLs and ADLs. In the preferred classification model, IADL and ADL items are combined into domains which conceptually can be associated with both community and residential care needs.

The IADL items and ADL items are grouped into domains of similar clinical meaning or purpose. A general need in a domain is identified with a screen question, which triggers further questions in that domain. The items in a domain investigate specific care need items. Further questions about unmet need and recent deterioration are also asked and used to identify care needs that require attention, these items then inform on the urgency (priority) of an intervention.

In this example there are six (6) domains that make up the Functional profile, each domain has varying number of items (refer to Table 6.4). These items and domains are only examples and will require data analysis and stakeholder consultations to confirm the final selection.

Table 6.4: Functional domains and item counts

Domains	Item count
Domestic Continence	2
Nutrition	3
Personal Care	4
Living Skills	4
Mobility	6

All functional items are rated on the same response scale (refer to Table 6.5).

Table 6.5: Functional item ratings and scores

Ratings	Independent	Emerging Difficulty	Some Assistance	Full Assistance
SCORE	0	1	2	3

Eligibility for the Low level of the base subsidy has been described previously in this paper as one or two items with identified low needs. This is the starting reference point for the determination of the Base subsidy. Further data analysis and stakeholder discussions will be critical to test any business rules and inform if the business rules require modification, the model can adjust to changes in determination rules.

Given these restrictions, we have provided an example of how to determine domain and base subsidy levels using the item rating descriptions. An alternative method would be to use scores but a scores based method is not discussed in this paper. Each domain is given a rating level of Low, Medium, High and Very High (refer to Table 6.6) based on the item ratings. Then the base subsidy is determined by applying the business rule that the highest domain rating determines the base subsidy level.

However, taking into account:

- (i) the higher resource levels associated with some domains (e.g. with more ADL items);
- (ii) the association to care supplements for some domains

There are also some recommended limits on the base subsidy levels associated to some domains.

Some of the considerations when determining domain and base subsidy levels were:

- Domestic, continence and living skill items by themselves are not high resource care needs in comparison to the ADL items in personal care and mobility. The very high level should therefore only be associated with high care needs in personal care and mobility.
- Domestic assistance is a common entry service into community care, and with only two items, logically it should not attract more than a medium domain and base subsidy rating. As all domains have the same domain business rule, this directed the rule that the *Highest item rating is FULL ASSISTANCE in one or two items= Medium domain level*.
- If a person needs nursing assistance with nutrition then they will be eligible for a care supplement for a complex health treatment and the other nutrition items do not require access to the high base subsidy. It is recommended that nutrition as a domain is limited to a medium base subsidy.
- Continence with two items is also potentially eligible for a medium domain rating; if it is a complex case it could be eligible for a care supplement and will not require a higher base subsidy.
- Living Skills are not as resource demanding as ADL items (e.g. possibly provided in a group setting), and they can be associated with a care supplement (e.g. medications). Taking into account the large number of items in the Living Skills domain it could (if following the algorithm) determine a very high base subsidy which is not congruent with the resources required, it is recommended that it be limited to a high base subsidy.

It should be noted that the priority has not been determined before the base subsidy is initially applied. The priority should be applied before referrals are considered as it takes into account if the needs are currently met. It is important to allow carers' access to the care supports when they currently meet all/some of the care recipient needs.

Table 6.6: Functional Profile and Domain Ratings

Description	Domains (Scope)	Business Rule	Domain Rating	Base Subsidy
One or two items with low needs	Domestic Contenance Living Skills Nutrition Mobility Personal Care	Highest item rating is SOME ASSISTANCE in one or two items	LOW	LOW
More than two items with low needs	Contenance Living Skills Nutrition Mobility Personal Care	SOME ASSISTANCE in three or more items	MEDIUM	MEDIUM
One or two items with high needs	Domestic Contenance Living Skills Nutrition Mobility Personal Care	Highest item rating is FULL ASSISTANCE in one or two items	MEDIUM	MEDIUM
Three items with high needs	Nutrition	FULL ASSISTANCE in 3 items	HIGH	MEDIUM
Three items with high needs	Mobility Personal Care Living Skills	FULL ASSISTANCE in 3 items	HIGH	HIGH
More than three items with high needs in a lower resource domain	Living Skills	FULL ASSISTANCE in 4 items	VERY HIGH	HIGH
More than three items with high needs in higher resource domains	Mobility Personal Care	FULL ASSISTANCE in 4 items	VERY HIGH	VERY HIGH

Care Supports

Eligibility for the Care Supports requires at least a base subsidy of at least LOW. They can be combined with any level of the base subsidy, and they can be areas of need that are not always directly related to functional impairments or conditions of the care recipient. For example:

- Community Transport
- Social Support
- Aids/Equipment/Home modifications
- Carer supports/ Respite
- Restorative programs
- Consideration of special needs e.g. ATSI, Rural remote

Care Supplements

The Care Supplement level consists of care needs that are not common across all clients, but have a high incidence and place the person at risk of residential care. They cannot be determined in full from the core needs assessments in IADL and ADL areas. Eligibility for Care Supplements requires a base subsidy above LOW. It is expected that more complex care clients will require assistance in at least one element of (the following are examples only):

- Health/ Palliative
- Nursing/Continence
- Dementia/Mental Health
- Rehabilitation

This layered approach allows for a flexible service pack that meets the assessed needs of the individual client. By attaching the base subsidy to the highest domain it ensures that all needs of the client can be met. The base subsidy can be designed with different service packs within each base subsidy level. Resources (e.g. hours of care) can be determined for each item or domain based on the item or domain rating.

For example:

More than two items with low needs (medium subsidy, eligible for care supports): This person may need 'some assistance' with light and heavy housework and shopping for food. Community transport may be of assistance for shopping if transport is the issue for the client. The service pack could include a set number of hours of home help for the housework and a set number of hours for a carer to take the client shopping if the community transport option does not meet their needs.

Three items with high needs (high subsidy, eligible for care supplements and supports): This person lives alone in their home of 30 years and has a diagnosis of dementia. They need full assistance with managing their finances and with all shopping (clothes and food), they have also been told not to drive. They are managing other household and personal activities. They also have reduced social and community participation due to the dementia. The service pack could include a set number of hours for a carer to take the client out weekly to do banking and shopping in the community, with possibly some financial management put in place. A dementia care supplement could be used to set up social activity programs for the client and place dementia aids in the house. The care support could provide technical aids such as an emergency call button to provide an emergency contact aid for the client's safety.

6.2.3 Case studies using the recommended classification model

A Low Base Subsidy provides access to a small number of services and care supports. While the final number of services and care supports is yet to be determined, case studies will be described based on one or two functional needs (either IADL or ADL needs) with one or two care support needs.

Case Study One: Low Base Subsidy (Mr A)

Mr A completes an on-line assessment with the help of his GP. Mr A has recently become a widower, he has no children or other family living nearby and he relied totally on his wife for all domestic needs such as cleaning and cooking. Mr A has indicated that he is independent (with no emerging needs) in living skills (managing finances and medications, using public transport), mobility, personal care and continence. He has however identified a need for some assistance with housekeeping and meal preparation. Mr A is eligible for community services and the assessment outcome is for a low base subsidy with one or two care supports. The hub made contact with Mr A to determine how best to meet his identified needs and to check there were no unidentified needs. They confirmed the identified need, confirmed it was an unmet need with a recent deterioration and applied a priority (refer to Table 6.1). In collaboration with Mr A, the intervention was briefly described at this point as low level domestic services (e.g. for 2 hours weekly) and access to a locally run 6 week restorative program that teaches cooking skills to men, with community transport provided. However, near the end of the restorative program, the service provider became aware that the cooking skills program was the main form of social interaction for Mr A, and they approached the hub to continue a social activity program for Mr A after the cooking skills program finished. The hub approved of the new intervention as it fit within the current classification scope, and as part of their review of the short term restorative program they contacted Mr A to review that program and to check he was happy with the new recommendation.

Case Study Two: Carer is currently meeting all care needs with no assistance (Mrs B and Mr B)

A couple (Mrs and Mr B) approached the community hub shop front to enquire about services they might be eligible for. Mrs B has been caring for her husband without any formal assistance for five years. His GP has recently re-assessed Mr B and his dementia has progressed from early stages to moderate dementia.

Mr B is continent, independently mobile, can feed himself, requires supervision (some assistance) with most of his personal care needs, but cannot manage any of the living skills items (finances, telephone, medications, shopping, public transport or social participation). Mrs B is in fairly good physical health (except

for some arthritis in her joints which limits heavy housecleaning), and she is reporting social isolation as she avoids many social situations as they upset Mr B. While Mr B has his current needs met and Mrs B strongly desires to continue in that role, Mrs B is at risk and is offered 2 hours of housecleaning a week (low subsidy based on her needs) and a suite of carer supports and restorative program (based on Mr B's eligibility for a high base subsidy).

Mr and Mrs B's case will be reviewed in 3 months after the restorative program finishes. It is likely that Mrs B will require more services in the future to assist her with her husband's care or to consider other options, as his condition can only deteriorate.

Case Study Three: Rapid Response from rehabilitation setting (Mrs C)

Mrs C had nearly completed her rehabilitation after a fractured hip as a result of a fall in her home. Once a discharge date was confirmed, the discharge officer assisted Mrs C to complete an online application for community services. The request was for a rapid response for domestic assistance and community transport. While Mrs C was fully independent prior to the fall with no need for community services, now she cannot drive her car or catch the local bus to do her shopping. She will be able to mobilise around her home with the help of a walking frame, cook and do light housework, and be able to attend to all her personal care needs with the bathroom aids that will be installed. The walking frame however means that Mrs C cannot attend to heavy housework. Together they partially completed the online application form, and faxed the requested evidence (to the hub) of Mrs C's diagnosis and functional assessments completed by the Allied Health staff.

The hub rang Mrs C at the rehabilitation unit, to confirm that the requested services would be in place on her discharge and an appointment to revisit the assessment was made in two weeks time. Mrs C was offered a telephone or face to face assessment.

6.3 DATA REQUIREMENTS

The data collection tool should be designed to produce objective and accurate outcomes, as required by the model. Each phase of the model has different outcome requirements.

The contact phase is carried out in varying modes of on-line, via telephone or face to face. It will:

- Identify information needs

- Provision of relevant nationally consistent information in an appropriate mode to meet the consumer's needs
- Determine broad eligibility
- Identify Rapid Response pathway
- Refer to the assessment pathway

The degree of success of the model in coordinating information and services underpins the ability to provide a fairly seamless journey for the consumers. All consumers can access information, and they should receive a nationally consistent level of information providing transparency about the system and enough depth of information to support consumer directed care choices. There will however be consumers that request and require assistance in navigating the system (e.g. due to cognitive impairment). It will be important to be able to detect the different types of consumers to provide them with the appropriate information and support level.

Data outcomes from the triage and information process would be primarily descriptive and important for planning purposes e.g. numbers of requests, types of requests, mode used, types of information provided, eligibility outcomes, assessment referrals etc. Basic eligibility to aged care services could be determined at this point before referring potential clients to the assessment pathway.

The initial needs identification is carried out in varying modes of on-line, telephone or face to face. It will;

- Identify emerging and current needs across a broad range of domains
- Identify clients that would be suitable for restorative type services
- Identify low resource service users, for quick assessment pathway to these services
- Trigger to second further assessment levels
- Generate outputs e.g. for care planning, referrals, information, data for reporting/research etc.

The second assessment level is to be completed via telephone or face to face with an assessor. It will:

- Provide enough data to determine the classification
- Provide accurate data that fits the requirements of all stakeholders
- Provide outcome measures of client needs
- Generate outputs e.g. for care planning, referrals, information, data for reporting/research etc.

The planning phase is to be completed via telephone or face to face with an assessor. It will:

- Provide outcome measures of client goals

- Prioritise the identified issues and needs in partnership with the client to broadly determine the interventions (supports, activities, services etc) most likely to succeed
- Provide a care plan which will determine the service provision requirements

The review phase is to be completed via telephone or face to face with an assessor. It will:

- Revisit client goals
- Evaluate the service provision
- Check the client status (unmet needs)

Planning, actioning and reviews are carried out by the hub assessor (client coordinator). These phases, if properly implemented, will allow the consumer to drive their own care planning (if they wish to). The needs identification will provide a good basis of information for the client to understand their needs. The planning process should be used as an opportunity to discuss and incorporate health promotion, disease prevention, treatment, and care coordination activities. The action process would use the system generated recommendations, allowing for client and assessor input.

One method of client input is through the goal setting activity. It can help the client to identify which needs are most important to them in the goal setting activity. It is important that the goal setting tool incorporate a measurement model that delivers a measurable outcome e.g. evaluates the outcomes. This could involve the Goal Attainment Scale approach which asks the client to state up to five issues that affect their quality of life, then rate how each issue impacts on their enjoyment of life e.g. on a scale of 1 to 5 where 1 is 'a fair amount, and 5 is 'extremely badly''. These issues are then evaluated at a later date using the same measurement approach. The recommended review process provides an understanding of whether the intervention/s was successful for the client and this also provides the hub with information with which to measure the effectiveness of their interventions (this is not a feature of current practice).

The Review would include:

- What was provided
- Service evaluation
- Client determination as to whether the interventions helped (goal setting included in this aspect)
- Review client status (any new or unmet needs)

6.4 STAFF SUPPORTS

Educational training, maintenance and support of staff will be critical in initially bringing (all types of) staff on board (this will include a major change element for many workers). All roles will require maintenance and development of their required skill set. All roles will require evaluation to determine if the role is producing the desired outcomes.

One of the assumptions often made is that a first point of contact with the public is a role for the 'receptionist' or is in a low skill level position, and therefore does not need much in the way of experience, qualifications or skills. However, in this model it is a vital role as this person has a great deal of influence on outcomes. The skill level for the triage role should not be underestimated. This position requires a complex range of skills that involve communication, perception and decision making. It also requires a comprehensive knowledge about aged care to direct the consumer to the right information. This role should encompass more than a generic approach, it needs to provide an individualised response, and accurately identify requests which may not be simple.

The Needs Identification assessment (for both levels) is best suited to a highly trained assessor, such as currently seen in the ACAT or CRCC agencies. It does not require the assessor to be an expert in any one speciality (as they can call on specialist assessors), but does rely on a depth of understanding, knowledge and skill in assessment practices, older persons needs and aged care services.

To provide a consistency for the client across the continuum of the phases, it is recommended that the needs identification staff take the client through the Planning/Actions/Review phases. Therefore the Needs identification assessor will become a client co-ordinator, and potential advocate for the client (depending on the client requirements). Assessors from current programs that provide comprehensive aged care assessment such as The Aged Care Assessment Services and CRCC would be suitable assessors for this central assessment role. They will also be required to input into the classifications (with IT algorithm and decision supports), undertake the initial planning and actions and the review phases. A review process is also common practice, but not in the standardised manner recommended in this paper.

While there will be some practice consistency for staff if they have experience working in the provision of aged or community care, it is imperative that the lessons learnt from the implementation of the Access Point (AP) demonstration project are not overlooked. The Access Point project was also trying to implement a central model approach in community care assessment. That project found that organisations or staff

continued with their old practices ignoring the new model principles, 'fitting' bits of the model (they were comfortable with) into their old practices. The objectives of the Access Point model were as a consequence, not consistently shared and operations varied widely from organisation to organisation. While organisations felt they were successful in meeting their own objectives but they were not considering the bigger picture objectives of the AP demonstration project. The importance of role of change management to bring all elements in the system on board and operating as planned cannot be underestimated.

The client coordinator will require specialist training on the use of the new assessment tool/s, the IT systems to support the assessment process, goal setting and measuring outcomes for planning and reviews. The staff will need to know what is expected of them in their role(s), why this is required of them, how to do it, the objectives of the model, and the benefits for consumers and other stakeholders. Therefore the ongoing educational and training requirements are considered central to the success of the implementation of the model.

There will be other external assessors who also interact with the model. All assessment staff would be required to strictly follow the Commonwealth Guidelines regarding the central assessment methodology for residential and community care. The transitional pathway option would involve Lead Agency assessors; therefore they will need to be accredited to some degree through training or a course to carry out their role competently. The Health system pathway option would involve another group of assessors whose current practice skills should be accepted, they are independent of the service provider, and they will only assess in their own speciality providing MDS items through a template.

Maintaining the currency of the tools and the supports

There should be on-going regular feedback and reviews of the usability of the software, tools and supports.

Competency based training

One possible way to establish and maintain a minimum level of required qualifications for a job role is to devise a competency based training (CBT) program. This would result in standardised training content that could potentially be delivered by the range of Registered Training Organisations (RTO) that provide education and training in this field.

Although training could be developed without it being accredited or competency based, there are benefits to any training developed being included in the national VET (Vocational Education and Training) curriculum. There would be more rigour applied to who could deliver and assess the training and the conditions under

which they could occur, and bring the competency into a regular review and revision timetable, thereby providing another source of quality assurance to the process.

On-going evaluation and review are critical elements to providing an efficient and effective training program to address gaps in skill levels, standards and training opportunities. This should include as a minimum:

- Providing consistent training and educational services in multiple modes/mediums to ensure assessors have access to the training
- Conducting regular reviews of the training provided and its demonstrated usefulness via feedback from assessors and by analysis of the effective use of the tool
- Reviewing and revising changes to the tool and the effectiveness of the consequent training provision

6.5 QUALITY ASSURANCE

The model, the process and the tool should ideally support a continuous improvement approach. The collection and storage of a set of standardised data will support the use of objectivity and reliable data for everyday purposes (e.g. client needs identification or service assessments) that can also be used as part of the evaluation approach of the quality assurance system. The quality assurance approach should assist to evaluate if the model has been implemented as planned and if the process is delivering the expected outcomes.

For example the data can be used to:

- Identify practices of concern e.g. incomplete assessment processes could indicate possible inconsistent assessment practices
- Identify possible system issues e.g. gaps in service provision types
- Identify at a higher level the need for detailed auditing

But only if the tool:

- Is based on objective and reliable data
- Produces informative outcomes e.g. includes measurable outcomes of the client needs and the service provision
- Is consistently collected - this determined by the process, the tool and the skill set of the users

The hub will play a pivotal role in the quality system in supporting the consumer:

- Providing information that consumers require to be capable to enact consumer directed care

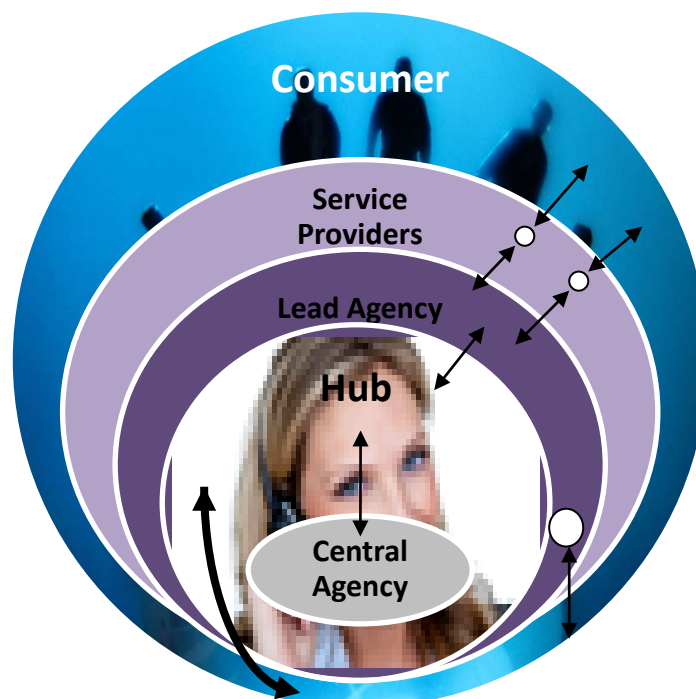
- Following a nationally consistent assessment process to support an equitable process for all clients
- Maintaining local networks to ensure a good understanding and relationship with the local service providers

The Hub and Service Providers will play a pivotal role in the quality system by providing reliable data:

- Collecting data for the national MDS, based on a standardised assessment tool/toolbox (nationally consistent data collection for QA process and policy determination). This will be an important tool for the QA process
- Ensuring their assessment staff are trained and provided with ongoing support

6.6 RELATIONSHIPS

Figure 6.2: Relationships and Roles



Central agency and the hub



The central assessment agency is the provider of all national materials and processes to the national network of hubs. The central agency would also coordinate all national training and educational requirements. The hubs supply data and local information back to the central agency as required.

There could be regional or locally situated hubs, and they could potentially be sub managed at the jurisdictional or local level. However the engagement with the model by the hubs is paramount to its successful operation. Boundary issues (e.g. between levels of government) may interfere with the successful operation of the model.



Hub and Consumer

The hubs are the on the ground services that receive contact with consumers via the multiple modes. Calls could be taken through a national 1800 number and directed to the hubs, or consumers could contact the hubs directly (face to face). Online queries could be initially triaged by the central agency or through the hubs; the model is flexible and can adjust to these types of requirements. Regional hubs can provide local expertise for callers, but the process should be the same for all callers ensuring equitable processes and outcomes for all clients. Clients can turn to the hub for independent advocacy at any time.

Hub and Lead Agency/Service Providers

The hub will be in contact the Service Providers in the Planning and Review stages. If there are multiple Service Providers, then the hub will primarily communicate with the Service Providers through the Lead Agency. This will help to streamline the communication regarding care planning and implementation. The Lead Agency and other Service Providers will provide documentation about the service provision and monitoring of the client for monitoring and planning by the hub.

In a network model, the hub would also collaborate with the local service providers to collect and analyse data about the delivery of services, reviewing the process and possibly researching best practices, particularly in partnership with evaluation expertise. The local network could tender for funding for specific projects and add to the body of evidence based knowledge.

Lead Agency and Service Providers

The Lead Agency will complete the Occupational Health & Safety (OH&S) check for all services. The Lead Agency (or broker option or the consumer) coordinates the service providers, collecting required documentation for the hub.

Client and Lead Agency

The Lead Agencies can have multiple roles with clients:

- Service coordinators
- Case managers (as required)
- Service providers (possibly)

They provide the client with a single point of contact with multiple service providers, thereby reducing the complexity for the client. It is possible in this model that the consumer will elect a broker or elect to do part of the role themselves.

Client and Service Providers

The Service Providers will provide services to the client. They will undertake service assessment to determine the best type of service delivery to meet the client's needs, completing reviews of the client status. Lead Agencies and service providers have the most frequent face to face contact with clients, which will put them in a position to best understand their particular needs.

6.7 ADVANTAGES AND DISADVANTAGES

	Advantage	Disadvantages/Risks
Central Process	Provides framework/structure for national consistency, pool assessor resources, reduce resource duplication. Nationally consistent assessment (MDS and toolboxes)	Must have training and education (change current practices, ongoing support), if not enacted it impacts on the consistency of the assessment and outcomes.
Regional hubs	Provide access for more consumers, collect localised information, assessors will be familiar with the client's environment and will understand the local programs, important role in developing networks with the community. Defines the access doors (this is not a 'no wrong door approach') and avoids a bottleneck at the central hub.	If run by local hospital networks- there was a concern voiced in the consultations that if aged care was run by the health system that the focus will be on bed shifting not the primary needs of the consumers.

Independent assessment	Adds strength to regulatory aspect	
Having skilled workers in triage	Does not underestimate the level of skill required to undertake this function properly. Important to get consumers interested in various support programs early, not after services in place e.g. restorative approach.	
Central call centre approach	Would provide a gateway that appeared to be easy to manage from a bureaucratic perspective.	Would underestimate the important role of triage, the worker needs have expertise about aged care and the local environments of the callers. Would not build regional relationships, partnerships and provide local responses to specific needs.
Lead Agency role	Lead Agency transitional role would initially reduce bureaucracy. They could assist special needs group in accessing the hub, taking into account any special supports required. Reduces duplication/overload of contact on hub from service providers. Reduces over assessment of client (by shared OH&S etc).	Lead Agency transitional role leaves open the possibility that they could 'capture' clients and direct them to their own services, and small agencies may disappear. Risk management strategy: As the hub will work with the client in service selection and provision, they can inform the client of all service possibilities. Secondly, data can inform on the hub and service provider practices. The data can highlight where hub coordinators or lead agencies are associated with expected client capture. Also it would be recommended that special needs agencies are 'block' funded to ensure their survival.
Both Care Recipient and Carer are assessed in their own right and in joint consideration.	Care needs should be investigated for both client types to ensure that the outcomes are appropriate for both parties. Only by independently assessing the carer can the carer sustainability issue be properly investigated.	
Consumer focus	CDC I supported by the model with strong information platform, goal setting, consumer choices, and back up coordination from hub and independent advocacy by hub	Consumer unable to self direct for example with cognitive impairment. Risk strategy: Hub client coordinator can guide the client, they are independent of the service provision

Quality Assurance	Model supports the approach with -Reviews - Measured outcomes - Objective and consistent data collection	
Low resource pathway	Quick assessment pathway	Risk strategy: Service provider can check the validity of the service request.
Rapid Response pathway	Quick services pathway	Risk strategy that a need has been missed because the request is self identified: contact client within 2 weeks to return to the assessment phase.
Broad identification of emerging and current needs	Comprehensive range of needs. Will target early identification/ prevention/ restorative approach	Restorative approach- need to ensure that the health system completes their activities before passing the client onto the aged care service (boundary issue).
Model	Extendable to multiple systems (disability etc). No need for packages Multiple communication methods Electronic Can be mapped to residential care funding.	

APPENDIX A

The Community Aged Care Assessment) at a glance and the ACFI at a glance' are provided in this appendix. It should be noted, that this version of a community assessment would require further development of specific domains and the items required. It is provided as a guide to demonstrate the general principle of mapping from the community assessment to the residential instrument. For example it uses ACCR (ACAT MDS) and ACCNA-R items, but the actual choice of items or domains could be modified.

Community Aged Care Classification at a Glance

Domain and Items	Data collected
DOMESTIC 'CARE NEED ITEMS' <ul style="list-style-type: none"> ▪ Light Housework ▪ Heavy Housework 	CARE NEED RATING for each of the items: Independent OR Emerging Difficulty OR Some Assistance OR Full assistance Rating of CARER ASSISTANCE for this domain: No-one available OR Informal Carer OR Service Provider OR Other Rating of CARE RECIPIENT IMPAIRMENTS for this domain: (Multiple selection) Physical; Sensory; Cognitive; Behavioural; Communication Rating of ENVIRONMENTAL ISSUES for this domain: Yes/No
NUTRITION 'CARE NEED ITEMS' <ul style="list-style-type: none"> ▪ Food Shopping ▪ Meal Preparation ▪ Eating/Drinking 	CARE NEED RATING for each of the items: Independent OR Emerging Difficulty OR Some Assistance OR Full assistance Rating of CARER ASSISTANCE for this domain: No-one available OR Informal Carer OR Service Provider OR Other Rating of CARE RECIPIENT IMPAIRMENTS for this domain: (Multiple selection) Physical; Sensory; Cognitive; Behavioural; Communication Rating of ENVIRONMENTAL ISSUES for this domain: Yes/No
LIVING SKILLS 'CARE NEED ITEMS' <ul style="list-style-type: none"> • Managing Finances • Telephone Use • Clothes Shopping • Medication management • Moving around the community- Transport use • Social and community participation 	CARE NEED RATING for each of the items: Independent OR Emerging Difficulty OR Some Assistance OR Full assistance Rating of CARER ASSISTANCE for this domain: No-one available OR Informal Carer OR Service Provider OR Other Rating of CARE RECIPIENT IMPAIRMENTS for this domain: (Multiple selection) Physical; Sensory; Cognitive; Behavioural; Communication Rating of ENVIRONMENTAL ISSUES for this domain: Yes/No

Domain and Items	Data collected
MOBILITY 'CARE NEED ITEMS' <ul style="list-style-type: none"> • Movement in bed: rolling supine to/from side lying • Transfers: supine (on back) to/from sitting • Transfers: sitting to/from standing • Locomotion/ambulation • Stairs 	CARE NEED RATING for each of the items: Independent OR Emerging Difficulty OR Some Assistance OR Full assistance Rating of CARER ASSISTANCE for this domain: No-one available OR Informal Carer OR Service Provider OR Other Rating of CARE RECIPIENT IMPAIRMENTS for this domain: (Multiple selection) Physical; Sensory; Cognitive; Behavioural; Communication Rating of ENVIRONMENTAL ISSUES for this domain: Yes/No
PERSONAL CARE 'CARE NEED ITEMS' <ul style="list-style-type: none"> • Toileting (exclude transfers) • Dressing/undressing • Washing self/bathing • Grooming 	CARE NEED RATING for each of the items: Independent OR Emerging Difficulty OR Some Assistance OR Full assistance Rating of CARER ASSISTANCE for this domain: No-one available OR Informal Carer OR Service Provider OR Other Rating of CARE RECIPIENT IMPAIRMENTS for this domain: (Multiple selection) Physical; Sensory; Cognitive; Behavioural; Communication Rating of ENVIRONMENTAL ISSUES for this domain: Yes/No
CONTINENCE 'CARE NEED ITEMS' <ul style="list-style-type: none"> • Urinary continence • Bowel continence 	'Care Supplement' identified CARE NEED RATING for each of the items: Independent OR Emerging Difficulty OR Some Assistance OR Full assistance Rating of CARER ASSISTANCE for this domain: No-one available OR Informal Carer OR Service Provider OR Other Rating of CARE RECIPIENT IMPAIRMENTS for this domain: (Multiple selection) Physical; Sensory; Cognitive; Behavioural; Communication Rating of ENVIRONMENTAL ISSUES for this domain: Yes/No
HEALTH 'CARE NEED ITEMS' <ul style="list-style-type: none"> • Medication • Complex Health • Health Conditions • Sensory • Communication 	'Care Supplements' identified Rating of MEDICATION CHECKLIST: Independent OR Carer Assist OR RN Assist < daily OR RN Assist daily Selection for 21 treatment items of COMPLEX HEALTH (Single Selection): Independent OR Carer Assist OR RN/AH Assist < daily OR RN/AH Assist daily List health conditions Rate health status, health stability and health interference with activities

Domain and Items	Data collected
REHABILITATION REHABILITATION CHECKLIST example (Yes/No for each): <ul style="list-style-type: none"> • 1-2 ADL deficits • Reversible health condition • CR Motivation 	‘Care Supplement’ identified
DEMENTIA/BEHAVIOUR/PSYCHOSOCIAL Five ‘CARE NEED ITEMS’ <ul style="list-style-type: none"> • Cognition • Problem Wandering • Verbal Behaviour • Physical Behaviour • Depression 	COGNITIVE CHECKLIST (Single selection)/ use score from set assessments or checklist: None or minimal OR Mild OR Moderate OR Severe Diagnosis of dementia or psychiatric diagnosis BEHAVIOUR CHECKLIST (Single selection) for three behaviour items/ possibly use score from Behaviour Summary: None or minimal OR Mild OR Moderate OR Severe DEPRESSION CHECKLIST (Single selection)/ possibly use CORNELL score: None or minimal OR Mild OR Moderate OR Severe Diagnosis of depression
CARE ARRANGEMENTS <ul style="list-style-type: none"> • Formal/informal supports • Services/resources used • Roles 	Care arrangements Profile Respite needs identified Service history
CARER <ul style="list-style-type: none"> • Carer type • Carer residence • Carer relationship to the CR • Carer role - how often they provide care, what type of care • Carer educational/training needs • PC-CR arrangements-sustainability • Caring burden • Carer health/functional needs 	Carer Profile Care supports identified Carer needs triggered
CARE SUPPORTS	Aids/ Equipment/ Assistive devices/ Home modifications Special needs groups Carer supports Respite Restorative Community Transport Social inclusion programs

ACFI at a Glance

	Question	ACFI Appraisal Evidence
Note: the Resident's ACCR must be included in the ACFI Appraisal Pack		
	MENTAL & BEHAVIOURAL DIAGNOSIS	<ul style="list-style-type: none"> Disorders/Diagnosis Table Source Materials Table Copies of Source Materials e.g. ACCR, GP Comprehensive Medical Assessment, other Medical Practitioner assessments or notes
	MEDICAL DIAGNOSIS	
1	NUTRITION Care Need: Readiness to Eat / Eating Assistance level = independent OR supervision OR physical assistance	<ul style="list-style-type: none"> Nutrition Checklist
2	MOBILITY Care Need: Transfers / Locomotion Assistance level = independent OR supervision OR physical assistance OR mechanical lifting equipment	<ul style="list-style-type: none"> Mobility Checklist
3	PERSONAL HYGIENE Care Need: Dressing / Washing / Grooming Assistance level = independent OR supervision OR physical assistance	<ul style="list-style-type: none"> Personal Hygiene Checklist
4	TOILETING Care Need: Use of toilet / Toilet hygiene Assistance level = independent OR supervision OR physical assistance	<ul style="list-style-type: none"> Toileting Checklist
5	CONTINENCE Urinary continence & Bowel continence Measurement = frequency	<ul style="list-style-type: none"> Continence Assessment Summary Continence Record Continence Checklist Documentary evidence of incontinence prior to implementing scheduled toileting (if appropriate) (Note: Other types of logs or diaries can be used to complete the Continence Record providing they contain all the required information)
6	COGNITIVE SKILLS Care Need: needs arising from cognitive impairment Measurement = none, mild, moderate, severe	<ul style="list-style-type: none"> Cognitive Skills Assessment Summary PAS if appropriate Cognitive Checklist (Note: A Clinical Report may be attached to provide supporting evidence)
7	WANDERING Care Need: Absconding or interfering whilst wandering Measurement = frequency	<ul style="list-style-type: none"> Wandering/Verbal Behaviour/Physical Behaviour Assessment Summary Wandering/Verbal /Physical Behaviour Records Behaviour Checklists (Note: Other types of logs or diaries can be used to complete the Behaviour Records providing
8	VERBAL Care Need: Verbal behaviour Measurement = frequency	

	Question	ACFI Appraisal Evidence
9	PHYSICAL Care Need: Physical behaviour Measurement = frequency	they contain all the required information)
10	DEPRESSION Care Need: Depressive symptoms Measurement = none, mild, moderate, severe	<ul style="list-style-type: none"> ▪ Depression Assessment Summary ▪ Cornell Scale for Depression ▪ Depression Checklist ▪ Diagnosis (Note: A Clinical Report can be attached to provide supporting evidence)
11	MEDICATION Care Need : assistance with medications Measurement = Complexity, frequency and assistance time	<ul style="list-style-type: none"> ▪ Source Materials Table ▪ Medication Checklist ▪ Medication Chart
12	COMPLEX HEALTH CARE Care Need: Complex Health Care Procedures Measurement = Complexity & Frequency	<ul style="list-style-type: none"> ▪ Source Materials Table ▪ Complex Health Care Checklist ▪ Diagnoses, Assessments and Directives as specified; ▪ If requested at validation - records of treatments

